DCCUMENT RESUME

ED 049 982 SO 001 109

AUTHOR	Wolk, Donald J., Ed.
TITLE	Drugs and Youth. Teaching Social Studies in an Age of Crisis, No. 1.
INSTITUTION	Naticnal Ccuncil for the Social Studies, Washington, D.C.
PUE DATE	71
NOTE	104p.
AVAILABLE FROM	National Council for the Social Studies, 1201 Sixteenth Street, N.W., Washington, D.C. 20036 ($2.25)
EDRS PRICE	EDRS Price MF-$C.65 HC Not Available from EDRS.
DESCRIPTORS	*Drug Abuse, *Drug Addiction, *Drug Legislaticn, Grade 10, Grade 11, Grade 12, *Health Education, Instructional Films, Resource Guides, Resource Materials, Secondary Grades, *Social Studies, Social Studies Units
IDENTIFIERS	*Drug Education

ABSTRACT

This pamphlet was written for social studies teachers to irform and stimulate the creative programing of drug education. Chapters written by the editcr were: 1) Why drugs?; 2) The Drugs of Concern; 3) Excessive Drug Use: Signs, Symptcms, and Family-Related Factcrs; and, 4) Four Rules for Teaching about Drugs. Other authors and chapter titles are: 1) Drugs in the High School: A Student Research Report, by James Velleman and Theodore Lawrence; 2) Social and Political Aspects of Drug Use, by George R. Edison; 3) Socio-Legal Policies on Drugs, by William H. McGlothlin and Louis J. West; 4) and Drug Education in Grades Ten, Eleven, and Twelve, by Sandra K. Florstedt. The appendix includes: a chart listing drugs, medical uses, symptoms; a drug glossary; a selected annotated bibliography; a discussion and listing of drug films; and, examples of drug education curricula. (VLW)

ED049982

"PERMISSION TO REPRODUCE THIS COPYRIGHTED MATERIAL BY MICROFICHE ONLY HAS BEEN GRANTED BY

NCSS

TO ERIC AND ORGANIZATIONS OPERATING UNDER AGREEMENTS WITH THE U.S. OFFICE OF EDUCATION. FURTHER REPRODUCTION OUTSIDE THE ERIC SYSTEM REQUIRES PERMISSION OF THE COPYRIGHT OWNER."

DRUGS AND YOUTH

DONALD J. WOLK, Editor

Teaching Social Studies in an Age of Crisis—No. 1

SP 001 109

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

NATIONAL COUNCIL FOR THE SOCIAL STUDIES
A National Affiliate of the National Education Association
1201 Sixteenth Street, N. W. Washington, D. C. 20036
Price $2.25

Copyright © 1971 by the
NATIONAL COUNCIL FOR THE SOCIAL STUDIES
Library of Congress Catalog Card Number 75-151826

The NATIONAL COUNCIL FOR THE SOCIAL STUDIES is a National Affiliate of the National Education Association of the United States. Membership is open to any person or institution interested in teaching the social studies. Each member receives the yearbook, a subscription to *SOCIAL EDUCATION*, and occasional other publications. Dues are $12.00. For further information, write to the Executive Secretary, 1201 Sixteenth Street, N.W., Washington, D.C. 20036.

PREFACE

The sudden addition of drug education programs to high school curricula is an obvious result of the widespread use of drugs by young people. Parents and educators hope that education about drugs will reduce the problem by turning students away from the danger. However, initial programs geared to this goal have met with little success.

The current drug scene cannot be divorced from contemporary social problems, from continuous scientific and technological changes, and from individual and family upheaval. The factors that provoke excessive drug use, and imprison youngsters in a drug culture, are as diverse and complex as the entire twentieth-century scene.

Therefore, this book, which was written and edited for secondary school teachers (and specifically for social studies teachers), explores a variety of components of the drug scene. Topics range from student attitudes regarding drugs to psychological and sociological reasons for drug use. A chapter on signs and symptoms of excessive drug use may prove beneficial for recognition of problem cases. Chapters concerning political beliefs, socio-legal problems, and family factors related to the use of drugs are applicable for classroom discussion. It is hoped that this book will not only inform, but will also serve as a stimulant for creative programming of drug education.

This book could not have been completed without the support and technical assistance of my wife. I am unable to count the ways in which she has been my inspiration and my strength.

Donald J. Wolk
University of Bridgeport

September 2, 1970

Teaching Social Studies in an Age of Crisis—No. 1
SERIES EDITORS: Daniel Roselle and Willadene Price

ABOUT THE EDITOR

Dr. Donald J. Wolk is Clinical Psychologist (Psychological Counseling Service) and Associate Professor of Psychology at the University of Bridgeport, Connecticut. Dr. Wolk, formerly associate director of the outpatient clinic at Connecticut Valley Hospital, was associated with the student division of mental hygiene at Yale University. He is a Past President of the Connecticut Society of Clinical Psychologists.

4

ACKNOWLEDGMENTS

Grateful acknowledgment is made to the following sources for permission to reprint their material:

Jack Shepard, "I Popped In the Pill. I'm Off," reprinted from *Look*, August 8, 1967, p. 23. Copyright 1967: Cowles Communications, Inc.

Psychedelics and the College Student (Supplemented edition, 1969, copyright © 1967 by Princeton University Student Committee on Mental Health): "A Successful Trip," and "An Unsuccessful Trip," pp. 16–18. Reprinted by permission of Princeton University Press.

Portions of chapters 2, 3, and 9 originally appeared in the *University of Bridgeport Alumni Quarterly*, Spring, 1968, and in *Social Education*, October, 1969, and have been revised for publication in this book.

James Velleman and Theodore Lawrence, "A Student Drug Survey," reprinted from *Schreiber Times*, Vol. 10, No. II, May 13, 1970, Paul D. Schreiber High School, Port Washington, New York. Reprinted with permission of the authors.

"A Schoolman's Guide to Illicit Drugs," reprinted from *School Management*, June, 1966, with permission of the publisher. This article is copyrighted © 1966 by CCM Professional Magazines, Inc. All rights reserved.

George R. Edison, "Social and Political Aspects of Drug Use." Used with permission from the *Journal of the American College Health Association*, Vol. 18, No. 4, dated April, 1970, pp. 274–277.

William H. McGlothlin and Louis J. West, "The Marihuana Problem: An Overview," reprinted from the *American Journal of Psychiatry*, September, 1968, Vol. 125, pp. 370–378. Copyright © 1968, the American Psychiatric Association.

"Drug Education in Grades Ten, Eleven, and Twelve," written by Sandra K. Florstedt, under the auspices of the Connecticut Department of Mental Health, April, 1969, pp. 2-12. Reproduced with permission of the Connecticut Department of Mental Health.

National Clearinghouse for Drug Abuse Information, National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015. For use of sections from *A Federal Source Book* and *Resource Book for Drug Abuse Education*.

•

PHOTO CREDITS. Photographs on pages vi, viii, 10, 28, 64, 78 by *Carl Purcell*, National Education Association; page 48 by *Carolyn Salisbury;* page 42, Housing and Urban Development.

5

CONTENTS

Preface iii

About the Editor iv

Acknowledgments v

1

1. Why Drugs?
Donald J. Wolk

11

2. The Drugs of Concern
Donald J. Wolk

29

3. Drugs in the High School: A Student Research Report
James Velleman and Theodore Lawrence

43

4. Excessive Drug Use: Signs, Symptoms, and Family-Related Factors
Donald J. Wolk

49

5. Social and Political Aspects of Drug Use
George R. Edison

57

6. Socio-Legal Policies on Drugs
William H. McGlothlin and Louis J. West

65

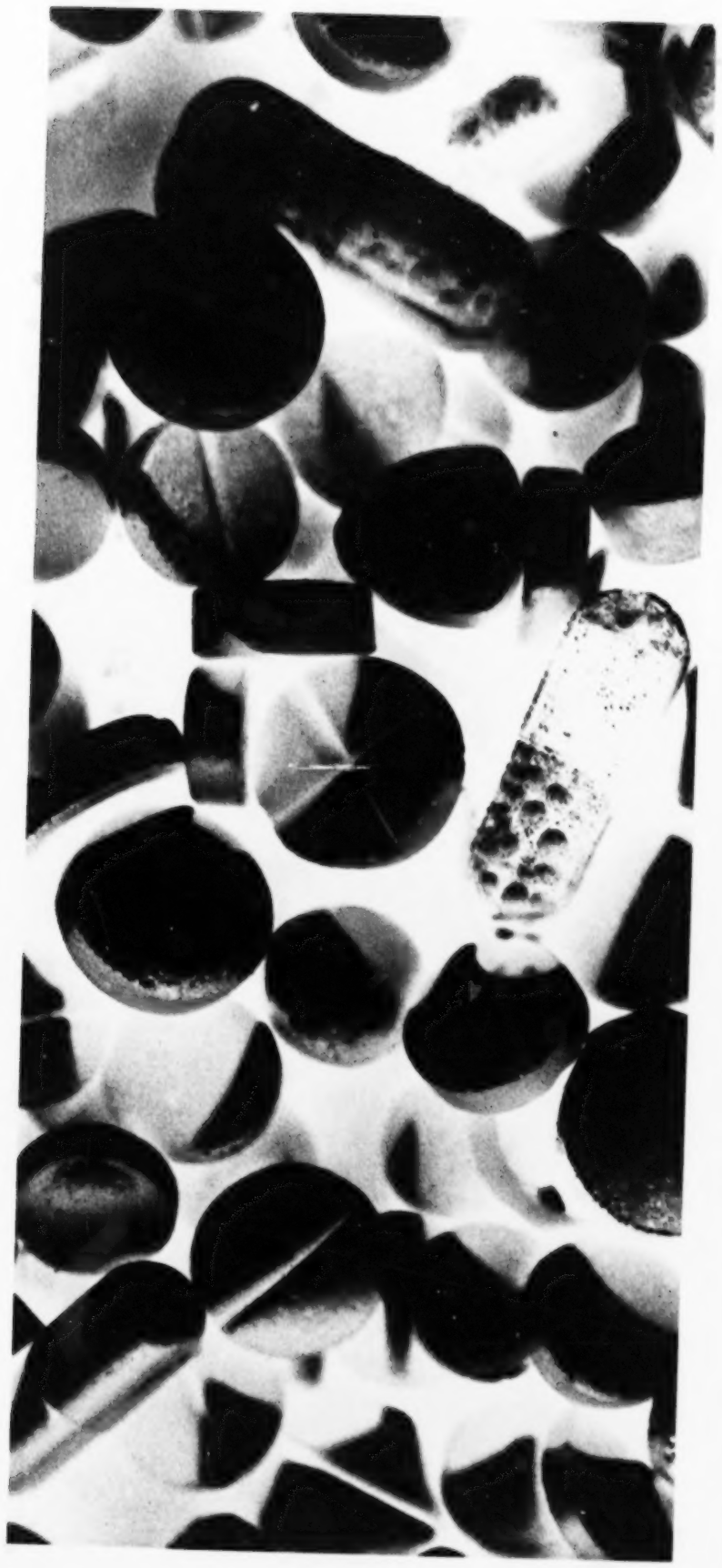
7. Drug Education in Grades Ten, Eleven, and Twelve
Sandra K. Florstedt

75

8. Four Rules for Teaching about Drugs
Donald J. Wolk

79

Appendix: Practical Drug Information for Teachers



1

WHY DRUGS?

DONALD J. WOLK

Instant solutions for our social ills and problems are endemic to American society.

> The American belief in speed, which led us to build railroads farther and faster than any other nation, to invent "quick-lunch" and self-service to save that terrible ten-minute wait, to build automobiles and highways so we can commute at 70 miles an hour, which made us a nation of instant cities, instant coffee, TV-dinners, and instant everything, has bred in us a colossal impatience. Any social problem that can't be solved instantly by money and legislation seems fatal. Our appliances and our buildings and our very lives seem out-of-date even before they are ready for occupancy. What can't be done right now seems hardly worth doing at all.[1]

Instant relief and instant gratification have become desirable goals for many people. Our society has seduced itself into believing that *drugs* provide quick, simple solutions for many personal and interpersonal problems. It becomes easier to ingest a change agent—a chemical remedy—than to expend the effort to understand the difficulties.

An atmosphere of acceptance for the use of drugs has developed. Increasingly more drugs are prescribed by overworked physicians; mass media advertise the virtues

of popping a pill and patients often demand tangible treatment for real or imagined illness. "This nation has become so medicine-oriented that patients demand antibiotics of physicians for the treatment of virus infections even though such infections are unaffected by antibiotics."[2]

One result is that many of our youth have turned to drugs and to experiences such as the following LSD "trip":

"I wanted to take LSD very much. I wanted to see what it is like, to take it the way the majority of college kids do: in an off-campus house, listening to folk-rock, looking at beads and psychedelic posters. How could I write about the college drug scene without getting involved in it? During work on our 'Potheads in Missouri' story, Vern Merritt and I took separate LSD trips on different days. Here is what happened to me, written from my notes and what I told Vern:

"11:50 p.m. Eight boys and two girls are with me in a cluttered, warm attic apartment just off the Missouri campus. We're all set to fly. One guy just gave me a small red capsule with, he says, 250 mcg of LSD. Everyone is happy and excited: 'You're going up with us tonight,' somebody yells at me. I really want to know what this is like. I pop in the cap, feel it with my tongue, swallow it. I'm off. I wait to get high, and read Kahlil Gibran.

"I feel excited, floating, happy. We smoke marijuana, passing the joint around, laughing, talking softly. They tell me that's a good way to float into LSD. Two candles glow in the room, and one dim light. I'm wearing beads a student gave me. There is a deliciously good feeling in the room. We joke about getting me to the St. Louis airport tomorrow, and one acid head tells Vern, who isn't taking LSD, 'Just put him in a trunk, man.'

"12:28 a.m. Oh, God—that's the first real feeling: The candlelight turns gold and flows like a tide across the notebook page. I can almost scoop it up. It ripples down the notebook, and I can turn the page and make it come and go. I look up: Colors move, the room comes alive, vibrant, glowing. I never realized this dull, brown room could glow so. An orange flame bursts from the candle, like an explosion on the sun. I'm seeing color for the first time. I drift in and out of this. I'm fluid, floating.

"Music is everywhere, clear, precise, as though I had stereo earphones on; it seems important. The words are sharp and profound. I read, and each sentence I look at

is clear, but all the rest are fuzzy. That's the way I see: What I stare at directly, I can see through. All of a sudden, I get a clear look at D---'s face, into his eyes, and see everything: Who he is, what he means. I can really see what he's like. The room flowers; I feel great.

"I'm playing with two squares of metal. I can see them exactly, the metal seems smooth, an extension of myself. I am metal and molecules and life; this metal is alive, colorful, sliding around in my hands like water. Everything I see, I see for the first time; I feel it is profound. I see the connecting pattern of life, the molecules that form metal and myself. They merge. Am I different from the dresser, the rug, the wall? We are alike.

"When I look into the metal, I see an endless landscape, lines stretching out into infinity, flat, purple, green, yellow, black lines; a bright-green tree in the middle distance. I can see the meaning of all life, infinity.

"I look over and see H---'s hand held upright, below the candle. I hold the metal square below the hand and they merge—metal, hand, candle—and they seem made of the same flowing, glowing, bright molecular substance. I click the fluid metal and hear a prolonged, lovely, cliiiiiick. Everything is in slow motion.

"Very quickly, and clearly, an old gilt-framed painting of the Madonna, in black with a gold halo, appears above me. The painting is sideways. I can snap sparkles from my fingertips. When I breathe, flowers spill down the front of me onto the floor. I shut my eyes and look at a candle and see, where my lashes meet, purples, greens, yellows, blues. My lashes part in a kaleidoscope of colors.

"But I'm playing games. My cheek muscles are tight, I'm gritting my teeth, holding back. Let go, let go. I do—and down I slide into the rug, falling into the pattern, the design surging up around me, engulfing me in light-red paisley prints, brilliant designs. It's wonderful and frightening, sliding away from myself.

"[I couldn't get comfortable on the floor. Students started coming in, and I got scared and thought they were going to hurt me. I didn't trust anyone. In the kitchen, one acid head, J---, began hyperventilating, breathing rapidly then blowing hard on his thumbs to make himself faint. He did, falling against the sink, cutting his head. The bloody towels and noise upset me.]

"My skin seems tight, the muscles in my legs, thighs, stomach and chest pull until I think I'll rip.

"The music, spilling beautifully over me from the

record player above, suddenly grows harsh and coagulates, slowing falling to crush me. I slide down on the floor to avoid it, I can't, it keeps coming, like the ceiling lowering, crushing me. God, turn it off. I've lost control. I can't bring myself out of it anymore. I'm trapped, forced to rise and fall into this beautiful, bright pit of color and sound. I see fish, purple baroque; lights, lots of lights, ON, OFF, ON, OFF. I'm really scared now, really cut off. It's no longer a game. I'm falling into an abyss, face up, that little glow of sunlight disappearing rapidly above me is my sanity. I want out of this. I'm really gone. I feel myself falling again and again, and I can't stop. Each time, I fall through bright pink, red, yellow, green, blue flowers and paisley prints and curls and scrolls of bright colors. I try to reach up, but I can't, and I fall into terrifying fear. I want out. This is going to be impossible.

"God, I feel so alone.

"2:05 a.m. I'm cut off from the others. Very frightened. My hands and feet seem far away. I'm not aware they're mine. I dissolve into things. My feet, hands jerk, and I slap my thighs rapidly. I'm scared.

"It isn't physical, I'm not straining to climb out. It's entirely mental, pulling myself up to the edges of my mental pit. When I get there, I see everyone clearly. I seem off the drug. Then I slide slowly back down, down into darkness.

"I'm not in control. I rise and fall to the music, in and out of the abyss. I'm frightened to know how far down I am. I can't come back to deal with things I know are there. I can't move outside myself; my mind reaches far beyond me. I want to leave, I can't. I'm aware of the dangers between here and the motel. I don't trust anyone in this room. They're all against me, trying to get me to do foolish things. They are hiding something from me. Did J--- die after he hit his head? I see the bloody towel on the floor from his fall. Something very serious happened to him; the others are keeping it from me. They are keeping secrets from me. They are hiding something. I ask three of them to leave the room. They bother me; their size and the way they act bother me. They are whispering about me. They leave, and I feel relaxed.

"My whole body jumps and feels jangly, electric. I think I'm shaking all over. D--- brings me orange juice in a large glass, and I hold it in both hands and gulp it down without stopping. I really need assurance; keep me on top. Am I shaking as much as I seem to be?

It's hard to breathe. I'm afraid of falling back into that abyss. There's a lot of physical pain to this, isn't there? My body aches, and I feel nauseated.

"Time seems elongated. I feel as though I've been through a long voyage, painful and interminable. I don't feel secure, I'm dropping off again. Damn, damn.

"Don't leave, don't go away. Please talk to me. I trust only D--- and Vern. D--- gets me a glass of water. I hold it in both hands on my stomach and lie on the floor. I dip two fingers into the water and wet my lips. The music scares me; I rise and fall on it.

"[I got into a birth position, feet up, knees bent, wiping water across my lips the way I did for my wife when our son was born a year ago. I have sharp pains in my chest, stomach, thighs and legs; pain rolls from chest to legs several times. I feel I've given birth.]

"I have no sense of reality, only rising and falling great distances in and out of sanity. Horrible. At 3:07 a.m., I want to leave badly, but I'm afraid to go outside. This is so ornate—all the way down and all the way out. I can [illegible] fish, green and blue, totem poles [illegible] feels like [illegible] another fall, I feel my body filling with bright-red air, and it and the room glow with an intense red color. D--- says softly, 'Relax, Jack, relax,' and the colors soften to yellows and blues and greens. The cycle starts again, the red growing stronger until D--- speaks. He doesn't see me, I don't look at him, but we feel—and need—each other in a strange, powerful way. He superimposes his will over mine. Without him, I'd drop so far down I couldn't get back. We laugh about this. He doesn't understand it either.

"5:15 a.m. I'm outside on Paquin Street. The sky glows with early dawn. I'm weak, unsteady, unsure of my body. The air feels cool and good. I try to walk, and seem to shuffle. Vern, D--- and I move down Paquin to Waugh. I'm slowly coming back. I know my name, I feel my feet moving, I smell the air. I can make it.

"I feel so alone. Vern snaps off a twig of honeysuckle flowers, my first contact with something real. I smell it: My God, it's alive and lovely and I'm all right. I could cry. I hold it gently . . . and walk back to the house. The horrible cycle of rising and falling is broken.

"6:05 a.m. At the motel trying to sleep, I get frightened, the room glows red. I smell the honeysuckle, and the room subsides into yellows and blues. Safe again. I carefully put the honeysuckle in the corner of each page of my notebook as I write. I see a vivid-green train wreck, then yellow-and-orange paisley beetles snapping playfully at me. A little dog scoots in and barks flowers.

"10 a.m. Blue sparkles shower from my fingers when I snap them. I write in this notebook, and turquoise flows slowly around the tip of the pen and spills like fog over the edge of the pad. My throat is sore, as though I'd been screaming all night. [Vern said I never raised my voice.] When I sneeze, sparkles of blue and green spill onto the floor. I'm still fighting the loss of reality. I feel myself falling again and I get slightly scared. I can stop it by thinking of things that are real and matter to me: my wife, kids, friends, job. I'm rebuilding my ego, piecing it together from these realities.

"I'm more aware now of colors and patterns, of the way people get frightened and cut themselves off from each other. I think I know better what love is. I was alone and far from people I trust and love. I got cut off from [illegible]. College students take risky [illegible]. What's happening to them?

"What if I had no identity, no sure realities? What if I were, as most college kids are, answering the awful questions of adolescence: Who am I? Where am I going? LSD doesn't give answers. Acid doesn't help them build an ego, it destroys it. I know that. I have never been more terrified in my life."[3]

Causes of Unrest

This is the *Age of Anxiety*, a term that has been popularized to a point at which people feel anxious just by seeing it or saying it. Causes for anxiety, as we know, include the threat of nuclear annihilation, the population explosion, the urban crisis, racial unrest, the Vietnam War, and ecological disasters.

Other causes of social and individual unrest include:

(1) the experience of being *flooded with stimuli*, by a wealth of information and feelings. Screening out "noise" becomes an automatic preoccupation of the individual. Eventually, the screen becomes "so dense that it isolates [man] as well from direct experience with the simple, the beautiful, the un-

expected in the world around him."[4] Drugs may be used to reduce the absorption of ideas and information, thus temporarily reducing confusion and frustration.

(2) the *pressure to achieve*—vocationally, academically, and socially. The prospect of having many avenues open to the young high school and college student is both exciting and threatening. The question that constantly confronts them in each of the three areas is: How do I go about choosing from all the alternatives available? Regardless of the choice, however, the push toward that elusive goal—"achievement"—is ever present.

(3) a highly *permissive society* accompanied by affluence and hedonistic attitudes. The war cry of youth is *freedom, independence, autonomy*. Freedom and permissiveness can lead to a more creative existence if supported and disciplined by limits and guidelines—notably for early and middle adolescent years.[5] Adults are uncertain about setting limits for their children. They are torn by contradictory [illegible] concerning child rearing. In [illegible] and other [illegible] enforcing [illegible] values; but we must keep in mind that these adults are also responding to their own needs and motivations. Not the least of these may be a conscious or unconscious desire for more freedom for themselves. This type of need may result in vicariously living through their children, unconsciously encouraging deviant, exciting, freedom-seeking behavior.[6]

(4) *organized religion, which has lost ground to humanism, reality, science, and technology*. Though still cherished as a precious heirloom, religion has failed to keep pace with today's needs, with today's attitudes and values, and with today's beliefs. People tend to turn inward and outward, but not upward.

(5) *the loss of symbols, authority, and established guidelines* has abandoned youth to the steel-tempered world of reality—a cold world of logic and hypocrisy. In the remaining void, *personal involvement, group identification*, and *belongingness* become essential. These are significant forces that draw and bind the individual to his peer group—and to the drug-oriented group. Once attachments are formed, especially those in which there is a strong common bond (such as

drugs), separation from the group becomes extremely difficult—even if desirable.

If the student decides that drugs are detrimental for him, he must ultimately choose between remaining or leaving the drug-oriented group. If he remains, he will eventually resume using drugs to some degree. If he truly decides to discontinue with this pattern of life, he will undergo much inner conflict, experiencing feelings of guilt, detachment, and loneliness. He will probably, for a time, lose his sense of belongingness to any group—and especially to the one with which he so strongly identified. It is not easy or pleasant to relinquish established bonds, even if the original, overt objective (in this example, drugs) is no longer desired.

Anxiety, stemming from ambivalent feelings about continued drug usage, is usually experienced. This eventuates in attempts to justify one's behavior through altering or distorting information which conflicts with the individual's newly-acquired beliefs. The heavy drug user will tend to rationalize, deny facts, and reveal a narrow, almost rigid manner of thinking concerning the drug subject. In general, he will convince himself, right or wrong, that drugs are healthy and effective.[7] Mamlet describes the magnetism of the group as follows:

> Within the group there arises remarkable pressure for intra-group conformity and ritualization, a pressure multiplied by the suggestibility of the drugged state and by the dependency strivings of many drug users. . . . Instead of openness and receptivity to new thoughts and ideas, preservation of this special group all too often requires the avoidance or negation of anything which complicates or calls into question the shared values of the group. . . . Students most deeply involved in this scene move toward ritualization of their drug experiences and all other social acts. . . .[8]

For some, drugs become "tied to a 'new spirit,' a new honesty, a new quest for substantial values and experiences. . . ."[9] The individual desires and seeks to become himself—to discover inner substance—to achieve a sense of adequacy and well-being. For others, drugs become the path to delusional peace, an escape from inner and outer turmoil.

FOOTNOTES

[1]D. J. Boorstin, "A Case of Hypochondria," *Newsweek*, July 6, 1970, p. 28.

[2]D. B. Louria, *The Drug Scene*. New York: McGraw-Hill Book Company, 1968, p. 16.

[3]J. Shepard, "I Popped In the Pill. I'm Off," *Look* magazine, August 8, 1967, p. 23.

[4]H. H. Nowlis, *Drugs on the College Campus*. A publication of the Drug Education Project of The National Association of Student Personnel Administrators, December, 1967, p. 26.

[5]Freedom is a double-edged sword. "Freedom of choice places the whole blame of failure on the shoulders of the individual. And as freedom encourages a multiplicity of attempts, it unavoidably multiplies failure and frustration. Freedom [also] alleviates frustration by making available the palliatives of action, movement, change and protest." (E. Hoffer, *The True Believer*. New York: A Mentor Book, 1951.)

[6]From: D. J. Wolk, "Why Marijuana?", *University of Bridgeport Alumni Quarterly*, Spring, 1968, pp. 8–11.

Roszak provocatively suggests that parents, unwilling to blame themselves for the alienation of their children, blame drugs. ". . . psychedelics become the convenient scapegoat for the misbehavior of the young. And the more banners the young fly for dope, the more adult society is hardened in its hostility to what is essentially an epiphenomenon of youthful rebellion." T. Roszak, *The Making of a Counter Culture*. New York: Doubleday & Co., Inc., 1969, p. 172.

[7]D. J. Wolk, "Marijuana on the Campus: A Study at One University," *Journal of the American College Health Association*, December, 1968, Vol. 17, No. 2.

[8]L. N. Mamlet, "Consciousness Limiting Side Effects of Consciousness Expanding Drugs," quoted in A. F. Philip, "Psychedelic Drugs and Education," reprinted from *Psychedelic Drugs*. New York: Grune & Stratton, Inc., 1969, p. 159.

[9]W. Simon and J. H. Gagnon, "Children of the Drug Age," *Saturday Review*, September 21, 1968, p. 62.

2

THE DRUGS OF CONCERN

DONALD J. WOLK

"Ups" (amphetamines or stimulants, including Methedrine or "speed" and cocaine), "Downs" (barbiturates), marijuana, and hallucinogens, such as LSD, mescaline, and psilocybin, are the major drugs used and abused by students. Heroin and glue-sniffing are special drugs used by selective groups within the drug world. Glue is primarily confined to high school grades and below; heroin is usually restricted to ghetto areas, rarely being seen on the college campus and occasionally in middle-middle and higher socioeconomic non-college groups (both white and black).

Marijuana

("pot," "grass," "tea," "mary jane," etc.)

Special emphasis will be devoted to marijuana, since this drug appears to be the most widely used by youngsters, and to be the most controversial.

In the year 2737 B.C., marijuana was first recorded in a Chinese pharmaceutical book as a prescription for: "female weakness, gout, rheumatism, malaria, beri-beri, constipation and absent-mindedness."[1] Since that time, marijuana has been used as an anesthetic in surgical operations, to relieve pain in labor and childbirth, and in instances of uterine dysfunction (such as dysmenorrhea). For thousands of years, marijuana,

in one of its forms, has been used as an euphoriant, as a remedy for physical and emotional maladies, and for religious and ceremonial purposes.[2]

Nowadays, it has been almost totally discarded as a medicinal device in favor of drugs that are more predictable and beneficial. Despite the fact that marijuana has been in use for almost 5000 years, much still remains to be learned regarding its chemical composition and its long-term physical and mental effects.

What is marijuana? Marijuana is obtained by crushing or chopping the dried leaves and flowering shoots of the female hemp plant, *cannabis sativa*. The small pieces may then be mixed and ingested with food or liquids, smoked as cigarettes or in pipes.

Hashish ("hash"), frequently confused with marijuana, has five to eight times the potency of marijuana. Although it is extracted from the same cannabis plant, only the resin from the top of the plant is used. Since hashish is a qualitatively more powerful drug, the teacher must make the distinction between it and marijuana. This will: (1) reduce confusion about drugs derived from the cannabis plant, and (2) establish teacher credibility when discussing various drugs.

The potency of marijuana is dependent on where it is grown and cultivated, climate and soil conditions, and time and method of harvesting. The drug's effects vary from person to person, and from time to time within the same person. The more prominent subjective effects of marijuana (which may last three to five hours) include: sudden, unexplainable hilarity (giggling and loud laughter); feelings of contentment and relaxation; a careless, carefree attitude related to the feeling of well-being; and distorted sensation and perception. A dreamy state may envelop the user so that ideas and feelings become disconnected and flow into one another. Mood may shift suddenly from joyousness to overwhelming depression or anxiety. Individuals may lose all sense of time and space; minutes may seem hours, near objects may appear far away. For some users (especially novices), a high state of intoxication may occur, resulting in poor coordination and faulty judgment (particularly detrimental when driving or attempting complex tasks).

Within the last several years the chemical component believed to be the potent element of the plant, cannabis sativa (marijuana), has been synthesized; this active ingredient is known as tetrahydrocannabinol (THC). Research is being conducted through the auspices of the

National Institute of Mental Health, the primary legal dispenser of the drug.[3] Thus far, the results remain unclear and tentative. High dosages of THC have been found to produce severe emotional reactions in every person tested, and psychotic reactions have been observed in some individuals.[4] However, THC is known to be many times more potent than the marijuana usually smoked outside the laboratory setting. Therefore, the generalization that "marijuana" is dangerous because it (THC) produced psychotic reactions in the laboratory is totally unjustified. One must be careful in reading and teaching the "facts" regarding drugs.

Zinberg and Weil reported an experiment they had conducted in the spring of 1968 in which the subjects were given marijuana cigarettes ("joints") to smoke—replicating as much as possible the "real world" in which the drug is used. Their conclusions are enlightening although, for some, frightening. Concerning physical effects:

> Marijuana caused a moderate increase in heart rate, but not enough to make subjects conscious of a rapid pulse, and it reddened whites of eyes. It had no effect on pupil size, blood sugar, or respiratory rate. Possibly the drug has a few other effects on the body . . ., but it is unlikely that other major effects will be found. [It is] unlikely that marijuana has any seriously detrimental physical effects in either short-term or long-term usage.
>
> All in all, we think it is fair to say in terms of medical dangers only, marijuana is a relatively harmless intoxicant.[5]

Moreover, the two researchers concluded that "marijuana seems to affect little in the brain besides the highest centers of thought, memory and perception. It has no general stimulating or depressive action on the nervous system—no influence in our lower centers like those controlling the mechanical aspects of speech and coordination. As a result it seems possible to ignore the effects of marijuana on consciousness, to adapt to them, and to control them to a significant degree."[6]

Psychologically, Zinberg and Weil state ". . . in short-term usage only . . . usual doses of marijuana do not impair a user's ability to carry out successfully a wide range of tasks of ordinary complexity. But higher than usual doses, especially in novice smokers, might be expected to cause performance decrements."[7]

Based on my own studies and clinical experience (on the college level) I can readily support the "psy-

chological effects" cited by Zinberg and Weil. However, we must also consider that the effect of the drug is dependent on several circumstances:

1. the mood of the individual (joyous, depressed, angry, etc.);
2. motivation of the smoker (to tranquilize, to become happier, to become more outgoing, to have sexual relationships, etc.);
3. the environment (setting) in which the individual finds or places himself.

These factors are crucial in evaluating and understanding the effects of drugs on the individual.

Many youngsters experiment, that is, take marijuana once, twice, or even several times, in order to satisfy their curiosity, and then discontinue use. These experimenters usually find the effects to be unpleasurable or not worthwhile for them. Or they do not want to risk being "busted"—caught by the police. Some take "pot" on occasion, from one to two times per month to several times per year. Still another group smokes the drug on a regular daily or weekly basis. Why do students, especially those in the last two groups, use marijuana?

Through clinical counseling and teaching contact with students, I have learned that there are multiple reasons for drug-taking, some of which are not readily apparent to the smoker.[8]

The reason most students cite is for a feeling of "relaxation" or tranquility. In this sense, marijuana serves as a relief from tensions and anxieties stemming from various academic, social, and personal pressures. For some, the drug becomes a necessary tranquilizer, relieving discomfort and boredom. For many other students, marijuana is a temporary "escape" from reality, and students readily admit this. What then occurs is *not* an increased tolerance for the drug, but an *increased intolerance for anxiety and frustration*—two ingredients in our lives which, within limits, serve a useful purpose in motivating us toward constructive goals and accomplishments.

The second most cited reason is a combination of increased sensitivity and awareness of others and the environment and increased insight into oneself. Students who are practiced in taking marijuana find that they are better able to appreciate art, music, nature, and a myriad number of mundane, often overlooked objects (such as tables, chairs, ashtrays, pencils, water, bubbles, etc.). Their senses, most usually sight,

sound, and touch, become more acute, and meaning is found in what was previously taken for granted.

Sensitivity to other people is heightened. Students report that they become more understanding and perceptive of the other person's communications (both overt and covert). They may then fully relate their feelings and interpretations to another person. These "therapy sessions" could be beneficial; but, more often than not, I suspect they are either innocuous or harmful. In some instances the "insightful" smoker projects (attributes) to others feelings and attitudes which lie within himself but of which he is not aware. Or, he picks up bits of information from talking with another person, formulates hypotheses, and believes that because he is high on marijuana his insights must be true.

It is important to recognize that, as a result of his relaxed, euphoric state, the individual who uses marijuana is more suggestible; he is, therefore, more easily influenced to believe something which may be clear distortion. This is where the danger lies: he will either convince himself or be convinced by others that the ideas and so-called insights he attained while using "grass" are valid. He may then proceed to react to and act on them; if these are false conclusions he will eventually increase his discomfort and move further from the truth, rather than closer. Moreover, the personal insight he gains is very often superficial and difficult to maintain once the drug effect wears off.

Other reasons mentioned by users of the drug include loss of inhibitions, a feeling of inner freedom to express themselves in a relatively unrestrained manner, and the desire and ability to work in a more effective manner (not cited very often). In regard to freedom of expression, the individual must consider the possibility that he may simply be rationalizing liberal behavior while under the influence of a drug. He will thus blame the drug for his behavior, removing the responsibility from himself. In some instances, release of inhibitions results in negative behavior, such as sadistic or unnecessarily cruel disparagement of others. This newly-discovered aspect of one's personality becomes disproportionately distorted, as the unsophisticated drug user believes it to be his "true self." This so-called "insight" may progress to self-devaluation, anxiety, and/or depression.

In terms of becoming more effective in work or study, most regular users state that it neither increases their creativity nor their productivity.

Other reasons have been expressed, some of which

include a challenge to authority, a desire to be caught and stopped (an unconscious wish for external care and control), and several others which are highly idiosyncratic.

Finally, the need and pressure to belong to and identify with a "hip" group, or with a group that offers the freedom to "be oneself," is tantalizing. This same sense of belongingness and of identification is a significant factor causing the regular user to feel bound to the drug-oriented group.

Since the psychological and sociological implications far outweigh the physical effects of marijuana, this should be the main area of discussion.

LSD (D-lysergic acid diethylamide)[9]

LSD is a special drug. Under its influence a person may rise to the heights of ecstasy, gaining sensitivity and insight, or he may fall to the depths of despair, feeling extreme loneliness and dread. For some, the experience may be beneficial; for others, the LSD trip may lead to further problems. Widespread publicity about the severe psychotic reactions resulting from it and the possibility of chromosome damage generated sufficient anxiety to turn youngsters away from the drug.[10] "Acid" has become too hot to handle, although its complete demise may not be seen for quite some time.

What is LSD? A synthesized drug of unbelievable potency, the "normal" LSD dosage (a barely visible 100-250 micrograms) can produce an 8–12 hour trip.

LSD is a derivative of ergot, *claviceps purpurea*, a fungus growing on rye and wheat. It was first synthesized by Stoll and Hofmann at Sandoz Laboratories, Switzerland, in 1938. During an experiment in 1943, Hofmann ingested a small amount of the drug, accidentally discovering its psychedelic or hallucinogenic features. He wrote:

> I noticed with dismay that my environment was undergoing progressive change. Everything seemed strange and I had the greatest difficulty in expressing myself. My visual fields wavered and everything deformed as in a faulty mirror. I was overcome by fear that I was going crazy, the worst part of it being that I was clearly aware of my condition. The mind and power of observation were apparently unimpaired.

Hofmann went on to list, as his most marked symptoms, visual disturbances, motor restlessness alternating with

24

paralysis, and a suffocating sensation. He then recorded that:

> Occasionally I felt as if I were outside my body. My "ego" seemed suspended in space . . . .[11]

LSD experiences vary according to several factors: mood and motivation for taking the drug, dosage and purity of the drug, and the environment or setting (a friend's house, a research laboratory—or taking it alone—may result in different "trips").

Subjective effects include intense perceptual changes (constantly flowing colors which appear vivid and beautiful); synesthesia (sounds that could be "touched," and light that could be "heard"); increased awareness and sensitivity to oneself, to other persons, and objects. Mood alters rapidly, from extreme happiness to uncontrollable crying and deep depression. The "trip" may include visions of oneself and/or others as horrid, frightening monsters; limbs seem distorted and flesh appears decayed. "Past, present and future may become confused. There may be depersonalization [an acute loss of self-identity] and distortion of the body image reminiscent of 'Alice in Wonderland.' "[12]

Two examples of psychedelic experiences will now be presented. The first is a successful trip; the second, an unsuccessful trip or "bummer."

A Successful Trip

"My sixth LSD experience started as I took 400 micrograms of LSD and waited thirty minutes for it to take effect. The first stage of the 'trip' was one of pure sensory ecstasy. LSD magnified enormously my capacity for aesthetic experience of music, art, architecture, and nature. Space and time changed. Sometimes it was stretched out as my mind worked faster and music sounded slow enough to be savored note by note. At other times, it varied between normal speed and a dead halt as my attention switched from the action around me to my own thoughts. My perception of distance and magnitude kept changing. Occasionally I could consciously control the variation. Walls seemed to bend as if made of a flexible material. I also experienced synesthesia, an integration of my senses; I could see music emerge from the speakers and drift toward me in three dimensions and in color.

"The second stage was one of recollection and self-analysis. My ability to remember, and practically relive,

many long-forgotten incidents was amazing. My self-understanding was greatly increased; it was something like going through several years of psychoanalysis in a few hours. I recognized that some of my values and attitudes result from particular incidents in the past which were traumatic. I learned a great deal about myself and this knowledge has helped me with the questions which I am now facing regarding my future.

"On this 'trip' I went beyond the second stage for the first time. The third stage is a non-verbal stage of symbolic images. Historical, mythical, and archetypal images filled my mind. Most of them involved characters and situations which said something about mankind and the meaning of life.

"The highest stage was close to a mystical experience. I find it difficult to express what little I can remember of this experience, but I felt that all my thoughts, emotions, sensations, and memories were fused into total understanding of myself and my place in the world."

An Unsuccessful Trip

"It was not my first trip that ended in chaos, it was my third. On my first two, my experiences were apparently conventional. There were gaudy lights, the grotesquely real new ways of looking at people, the rapid experiencing of sights, sounds, and feelings. My friends told me that this was expanded consciousness, and so I believed them. Afterwards, I did seem to be able to have new insights on my friends and family, at least after talking with my friends, and I was willing to overlook the very frightening moments of anxiety early in the trips through which my guide helped me.

"But it was my third, as I say, which was disastrous. Why, I cannot say. The dose was supposed to be the same (but you can't be sure, of course, unless you're a chemist and have made it yourself). The room was the same, and the guide was there with me. I anticipated greater ecstasy.

"But it was early in the trip that I noted that his face was more distorted than usual—strange, I never noticed how ugly he could be. And why did he have to shout at me so loudly? And then it was upon me, that searing pain in my chest, stabbing and growing. I dashed for the kitchen to get a knife to cut it out, but the doorway wasn't there. My guide caught me, held me, and in an hour (or so it seemed), it passed.

"Then, I dreamed that I got into a subway, thinking

that I would ride it to the end of the line. At once these words, 'end of the line,' assumed awful and multiple proportions. I felt drawn and impelled towards this 'end of the line' where Some Thing was waiting and beckoning. I felt there I might find fulfillment or destruction, or both.

"At other times, I awakened into an increasingly incredible and terrifying world. I stood on the edge of a giant elevator shaft, which extended down into the infinite. And insane-looking men kept passing into the elevators and coming out again—the same men, over and over.

"Then it was pleasant for a while. A ray of sunshine came in the window and illuminated not only the room but the inside of our bodies. I was light, I floated. I could float up into the sky. I went to the window, but it was locked; the door, that was the way to fly! I was out of it before my guide could catch me and flying down the stairs. And then the sickening pain in my left shoulder (I afterwards found that I had been caught at the bottom of the stairs, and that my shoulder had been dislocated at that moment). The pain overwhelmed me, and I could no longer recognize people.

"It was later that I began to have some contact in the drab ward of the hospital, but not for four weeks was I free enough of hallucinations and ordered enough in thought and action to be released. Now, three months later, I am approaching a point at which I can return to college.

"What about consciousness expansion and mystic experience and new meaning of life? A few of my friends insist that they have all these, and perhaps some do. But it is all too easy to term a rapid jumble of thoughts an increase in consciousness if your friend considers that he has had a mystic experience merely because he has for the first time been able to talk with friends about his feelings and theories; what I don't know about him is whether his feelings are the influence of the drug or the influence of the group."[13]

Five Dilemmas

The questionable value of these "trips," or "psychedelic journeys," provides material for discussion. Simmons and Winogard, in their interesting and provocative book, *It's Happening*, expand on Dr. Timothy Leary's five major dilemmas arising from psychedelic journeys.[14] The series of fears are "balanced against the

series of yearnings." My own "balanced" commentary follows the listed dilemmas.

1. "The terror of loss of rational control is balanced by the hope of transcending one's hidebound ways of thought and freeing oneself from programmed ruts."

   We are fully aware that the "terror" is an occasional happening, even to those who have used the drug many times. Brief (acute) psychotic episodes and anxiety reactions resulting in a "loss of rational control" while under the direct influence of LSD have been reported numerous times. Moreover, the phenomena known as "flashbacks" have been related more often as the years go by. A flashback is a spontaneous recurrence of unpleasant sensations from an LSD trip experienced weeks or even months before. Suddenly, the individual, who had his last trip three or four months ago, becomes unexplainedly anxious or depressed while reexperiencing some of the terror of that trip. This occasionally results in prolonged, severe anxiety or depressive symptoms, loss of emotional control, a fear of going crazy and/or panic (an overwhelming experience of dread). The most frightening feeling, as related to me by several students to whom this had occurred, was that of losing control of one's emotions and thinking, and, therefore, of one's mind.

2. "Fear of acting shamefully is balanced by the hope of casting off one's social fetters and behaving as one truly wants to."

   For many, the task of casting off an undesirable and uncomfortable social mask is extremely difficult. However, becoming more of one's self can also be accomplished by self-examination and requested feedback from others. In my opinion, deep and trusted inter-personal relationships become more meaningful, freeing, and satisfying than those emerging from a drug experience. However, the utility of a chemical catalyst is a thought to ponder and discuss—if a "safe" drug is eventually marketed.

3. "The terror of perhaps really seeing yourself is balanced by the hope of really finding yourself."

4. "The fear of disenchantment with one's society and one's position within it is balanced by the hope of insight into the inner workings of one's social environment and of seeing more creative alternatives."

The "hope" within each dilemma is one that, I am sure, most of us desire. The question is whether to risk the danger of the drug and the experience, or seek other means to achieve the same goals. "Haste makes waste." "A stitch in time saves nine." Which shall it be? What are the alternatives for seeking self and of better understanding one's environment? These are the questions that need discussion.

5. "And, the fear of discovering a 'super-normal' realm so pleasant that one will never return is balanced by the hope that one can reach a level of awareness which will transform everything into splendor."

   Who will deny the secret desire for a utopia of one's own making? How long does "splendor" last? It may last as long as one continues to strive for openness, honesty, and spontaneity, or as long as one is sufficiently tranquilized so as to block all unpleasant realities. Alas, all too often, students I have seen have had to continue on either LSD or other drugs to relive the splendor of the moment. It is too easy to become dependent on a chemical that promises the secret of contentment. Is this type of existence delusional or real? Who is to decide? The individual or the society?

These five dilemmas and the commentary following are grist for the social education mill. To discuss the effects and uses of LSD, such as in psychotherapy or in treating alcoholics, for terminal disease cases, and for autistic children, would not be within the realm of this chapter.[15] Of importance here is having students think through the personal and societal meaning of drug use.

Amphetamines, Barbiturates, and Glue Sniffing

Amphetamines

"No aspect of drug usage is totally alien to the culture in which it exists; however, the speed [amphetamine] scene appears especially compatible with American culture. Its stimulative effects subject it to the 'bigger and better' competitive spirit inherent in our tradition. Persons have the illusion of living more even if they are in fact accomplishing nothing."[16]

Amphetamines (stimulants, otherwise known as "ups" or pep pills) are a pick-me-up. They offer relief from depression and fatigue, a feeling of alertness and wakefulness, and an increased ability to concentrate, think, speak, and perform more effectively.[17] They are

often prescribed for weight control and diet purposes. However, it is important to note that unexpected effects may occur.

"Following the birth of my third child, I began to put on weight. My other two children were ages two and five and, because I was confined to the house most of the time, my favorite occupation became eating. It finally got to the point where I couldn't stand myself anymore, so I went to my doctor for a fast, easy, painless cure. He prescribed the appetite suppressant 'Preludin,' [an amphetamine], 25 mg. tablet, one to be taken one (1) hour before each meal. It certainly did curb my appetite—I was so stimulated and had so much energy that I no longer had time to eat. The walls—the floors—the ceilings—everything was scrubbed. There was no physical activity that was too hard—I was indefatigable. But when it came to cooking, or reading, or sewing, or anything that required organization or slow movement, I was unable to perform. My mind was working overtime along with my body, and my thoughts were never completely formed because I was already on the next thought. In short, I was a human dynamo—beware of anyone who got in my way while I was whirling. The funny thing was though—no matter how stimulated—the pills did not prevent me from sleeping at night. I guess I was just so completely physically exhausted that nothing could keep me awake. Needless to say, when I reported these side effects to my doctor some few weeks later, he had me stop taking them immediately at which time I experienced something which must be similar to withdrawal symptoms. For a few days, I was listless, tired, irritable and very hard to live with—I craved just a little of my former pep and energy, but, eventually, that too passed, and I returned to my usual former self."[18]

The drug of prime concern in the amphetamine category is "speed" (methamphetamine or Methedrine). This drug is usually taken intravenously for a quick, potent boost. The individual experiences feelings of mental and physical alertness and power, a wild, joyous attitude, and the capability of talking and working till all hours of the morning and night. It is a high feeling, very often an avoidance of, or escape from, unpleasant sensations of inadequacy, depression, loneliness, and alienation. The world is too cold, gray and demanding; it is more pleasant to float on the billowy clouds of "speed." Sleep is not necessary as long as the individual continues taking his "meth." Of course, the user of pep

pills cannot continue this behavior indefinitely; his body, if not his mind, requires rest.

Under heavy doses of Methedrine, the user is usually unable to sit still. Restless and fidgety, he may experience muscle and joint pains, and muscular twitchings. In some instances, compulsive concentration on minor tasks (such as stringing beads for hours) may be observed. Attention may wander from one compulsive task to another.[19]

The fall (coming down) is painful; depression and fatigue quickly set in, and it becomes increasingly more difficult to remain on the ground; that is, without outside support, understanding, and guidance. Discontinuation of the drug (especially after long "runs") can result in depressive or anxiety reactions, accompanied by feelings of lowered self-esteem and apprehension about one's present stability and future.

For some, continued use of amphetamines may result in acute paranoid psychosis. Visual and/or auditory hallucinations, suspiciousness, delusions of persecution, and variable amounts of anxiety will be experienced and observed. This psychotic reaction is usually temporary, lasting several days, once the drug has been discontinued.

Although amphetamines do not produce physical dependence, a tolerance to these drugs does develop so that larger and larger doses are required to feel the effects.

Barbiturates

Barbiturates (sedatives, otherwise known as "downs," "goofballs," and by many other names) are the quieting-down drugs. They are taken by youngsters to alleviate tension and anxiety, to induce sleep, and to experience a fast, pleasant "drunk." In higher dosages the effects and the experience are usually those of confusion, slurred speech, uncoordinated walking, and an inability to think and work effectively. Heavy users may eventually show signs of instability, anger, and combativeness. Much of the behavior evidenced while under the influence of barbiturates is dependent on the personality of the user, his motives for taking the drug, and his prevailing mood.

Continued barbiturate use and abuse may lead to psychological and physical dependence; that is, the body develops a need for higher and higher doses of the drug which, when suddenly discontinued, may result

in withdrawal pains. This "abstinence syndrome" is primarily experienced as anxiety, dizziness, cramps, nausea, and delirium; convulsions and death may occur in some cases.[20] Moreover, as a consequence of the intoxication effect, users may become confused about the number of pills ingested. ". . . not getting the desired effect within what seems to him a long time [the user] continues to take tablet after tablet until he is unconscious. In the process, he may ingest a lethal dose."[21] Barbiturates are reported to be a leading cause of accidental poison deaths in this country.

The free use of barbiturates and amphetamines once again points out the desire and urge to resolve all problems through a pill or an injection. This is a social phenomenon and problem which is not easily accepted or resolved.

Glue—or Solvent—Sniffing

Many of the reasons youngsters sniff glue and inhale other solvents (such as gasoline, lighter and cleaner fluids, lacquer thinners, etc.) are similar to some already cited for marijuana use, namely: curiosity, to experience a fast "high," to have pleasant sensations, rebellion and/or to escape from an unpleasant reality. Glue and other solvents are used by younger teenagers because they are inexpensive and readily available.[22]

Inhalation of glue may produce feelings of exhilaration, drunkenness, omnipotence, and general euphoria. Some individuals experience pleasant emotions and have peaceful thoughts and imagery; others undergo unpleasant, anxiety-laden experiences in which terrifying thoughts and hallucinatory material emerge.

". . . for most individuals solvent-sniffing is indulged in transiently and, except for occasional instances of injury, suffocation or violence, no permanent scar is left. A small number of individuals will become severely habituated, and for them glue- or gasoline-sniffing is a very serious problem which often results in aggression, violence, or delinquent behavior, increases psychological isolation, accentuates personality defects, and may result in permanent brain dysfunction."[23]

Heroin

Heroin (an opiate commonly referred to as "H," "smack," "horse," etc.) is a total escape drug. The relief and joy experienced reinforces its repeated use. The desire and necessity to involve oneself with the mundane

affairs of the "straight" world gradually decrease; the user becomes primarily interested in and concerned with himself and his drug—his major goal and challenge is in acquiring the drug and turning himself off.

Heroin is a semisynthetic derivative of morphine, which (with codeine) is an active chemical in opium. The drug opium, used for centuries in Asian and African countries as an euphoriant, is taken from unripe seed capsules of the opium poppy, *Papaver somniferum*.[24] Morphine is extracted from opium for medicinal use (e.g., relief from severe pain), and can result in physical dependency when abused. Heroin, which is relatively simple and inexpensive to produce, and more potent than morphine, has no medicinal usefulness.

Heroin is an insidious, self-destructive drug. It is usually sniffed ("snorted") by beginners, later injected subcutaneously—beneath the skin—("skin popping"), and finally, by chronic users, the drug is "mainlined" (injected into a vein).

For those persons who develop a psychological dependence on heroin, it usually becomes addicting. This results in physical withdrawal symptoms (the "abstinence syndrome") when the drug is discontinued. These symptoms include: anxiety, body aches, restlessness, insomnia, hot flushes, nausea, diarrhea, abdominal and other muscular cramps. The syndrome has been likened to "a bad case of gastrointestinal influenza."[25]

However, these symptoms are not as debilitating as they were thought to be. Expectations to undergo great physical pain when withdrawing from heroin create an anxious, tense attitude. Expectancy then leads to the actual experience of unbearable pains. Apparently this is more psychologically and socially induced than physically necessary. In describing an average withdrawal scene at one of the more successful treatment centers, Daytop Village, Alexander Bossin writes:

> He [the addict] goes through withdrawal on a couch in the living room with residents all about him, laughing, playing cards, listening to music, dancing. He is too ashamed to put on the expected exhibition of wall climbing and swinging from chandeliers. He knows that these people will not be impressed by his performance. He knows there will be no payoff for his histrionics from these wise, hardnosed critics. And somewhat to his own surprise, he kicks the remnants of his [physical] habit in record time with no more discomfort than the average guy with a mild case of flu.[26]

Medical complications which may accompany addiction to heroin include hepatitis, venereal disease, skin infections, tuberculosis, pneumonia, bronchial asthma and malnutrition.[7] Moreover, this "habit" could cost upwards of forty dollars a day; to finance their drug supply, addicts often turn to criminal behavior (usually theft and/or prostitution).

Most of those who become addicted have psychological problems, but this is not to say that addiction can be viewed only from the point of view of the individual and his family background. The problem is a sociological one as well.

"At present only 30 percent of all addicts in the United States are Caucasian. Heroin abuse is primarily a disease of repressed minorities; 50.4 percent of the users are Negro, 13.6 percent Puerto Rican and 5.4 percent Mexican."[8]

Heroin is a ghetto drug. It is readily available, and all too easily accepted as one means of escaping from an impoverished, depressing environment. For the affluent, drugs serve as a means to immediate pleasure, relief, and gratification. For people in the ghetto, the need is to escape from a "blighted reality." In one population we find a lack of discipline and an overly-permissive attitude; in the other we see deplorable social conditions which produce blind alleys and endless frustrations.

FOOTNOTES

[1]Norman Taylor, "The Pleasant Assassin: The Story of Marihuana," in *The Marihuana Papers* (edited by David Solomon). Indianapolis: Bobbs-Merrill Co., Inc., 1966.

[2]R. H. Blum & Associates, *Society and Drugs: Drugs I*. San Francisco: Jossey-Bass Inc., Publishers, 1969.

[3]NIMH is currently supporting approximately 124 drug-based research projects all which do not related to marijuana. Areas being studied range from psychosociological studies of drug abuse and abusers to "genetic studies to determine effects on chromosomes and offspring," to the development of materials for educational purposes.

[4]"Students and Drug Abuse," *Today's Education*, March, 1969.

[5]S. E. Zinberg and A. T. Weil, "The Effects of Marijuana on Human Beings," *The New York Times Magazine*, May 11, 1969, p. 89.

[6]*Ibid.*, p. 92.

[7]*Ibid.*, p. 98.

[8]J. J. Wolfe, "Why Marihuana?", *University of Bridgeport Alumni Quarterly*, Spring, 1968, pp. 9-11.

[9]Mescaline and psilocybin are two other psychedelic drugs used by students with effects similar to LSD. Mescaline is the most potent extract found in the buttons or tops of the small peyote cactus, *Lophophora williamsii*. Psilocybin is the active principle in the mushroom, *Psilocybe mexicana*. For more detail concerning these and similar drugs see: R. E. Schultes, "Hallucinogens of Plant Origin," *Science*, 163, No. 3865, January 17, 1969, pp. 245-254.

[10]See: C. B. Jacobson and J. L. Magyar, "Genetic Evaluation of LSD," *Clinical Proceedings* of the Children's Hospital of the District of Columbia, 24, No. 5, May, 1968, pp. 153–161.

[11]A. Hofmann, "Discovery of D-lysergic Acid Diethylamide—LSD," *Sandoz Excerpta*, 1955, 1:1–2; in S. M. Unger, "Mescaline, LSD, Psilocybin, and Personality Change: a Review," *Psychiatry*, 26, 1963, pp. 111–125.

[12]H. H. Nowlis, *Drugs on the College Campus*. A publication of the Drug Education Project of the National Association of Student Personnel Administration, December, 1967, p. 93. For a further description of the LSD experience, see: J. P. Smith, "LSD: The False Illusion," *F D A Papers*, July-August, 1967.

[13]Student Committee on Mental Health, Princeton University, *Psychedelics and the College Student*. Princeton, N.J.: Princeton University Press, 1967, pp. 15–18. For other examples of "trips" see: S. Cohen, *The Beyond Within: The LSD Story*. New York: Atheneum, 1967; and H. A. Abramson (editor), *The Use of LSD in Psychotherapy and Alcoholism*. New York: The Bobbs-Merrill Company, Inc., 1967.

[14]J. L. Simmons and B. Winogard, *It's Happening*. Santa Barbara, California: March-Laird Publications, 1966, pp. 50–51.

[15]For information regarding these areas see: H. A. Abramson, *op cit.*

[16]Margaret Ann Burk, "Speed: The Use of Amphetamines on the Campus," *Journal of the National Association of Women's Deans and Administrators*, 32, No. 3, Spring, 1969, p. 113.

[17]A.M.A. Committee on Alcoholism and Addiction, "Dependence on Amphetamines and Other Stimulant Drugs," *Journal of the A.M.A.* 197, September 19, 1966, pp. 1023–1027.

[18]This account of prescribed amphetamines was reported in class by one of my students who then wrote it up on request.

[19]For an interesting and "colorful" account of the use of amphetamines and Methedrine see: J. T. Carey and J. Mandel, "A San Francisco Bay Area Speed Scene," *Journal of Health and Social Behavior*, 9 (2), June, 1968, pp. 164–174.

[20]For a more detailed description of the physical and mental effects of these drugs, refer to N. B. Eddy, *et al.*, "Drugs Dependence: Its Significance and Characteristics," *Bulletin of the World Health Organization*, 1965, 32, pp. 721–733.

[21]A.M.A. Committee on Alcoholism and Addiction, "Dependence on Barbiturates and Other Sedative Drugs," *Journal of the A.M.A.*, 193, August 23, 1965, pp. 673–677.

[22]E. Press and A. K. Done, "Solvent Sniffing," *Pediatrics*, Vol. 39, Nos. 3–4, March and April, 1967.

[23]D. B. Louria, *The Drug Scene*. New York: McGraw-Hill Book Company, 1968, p. 52.

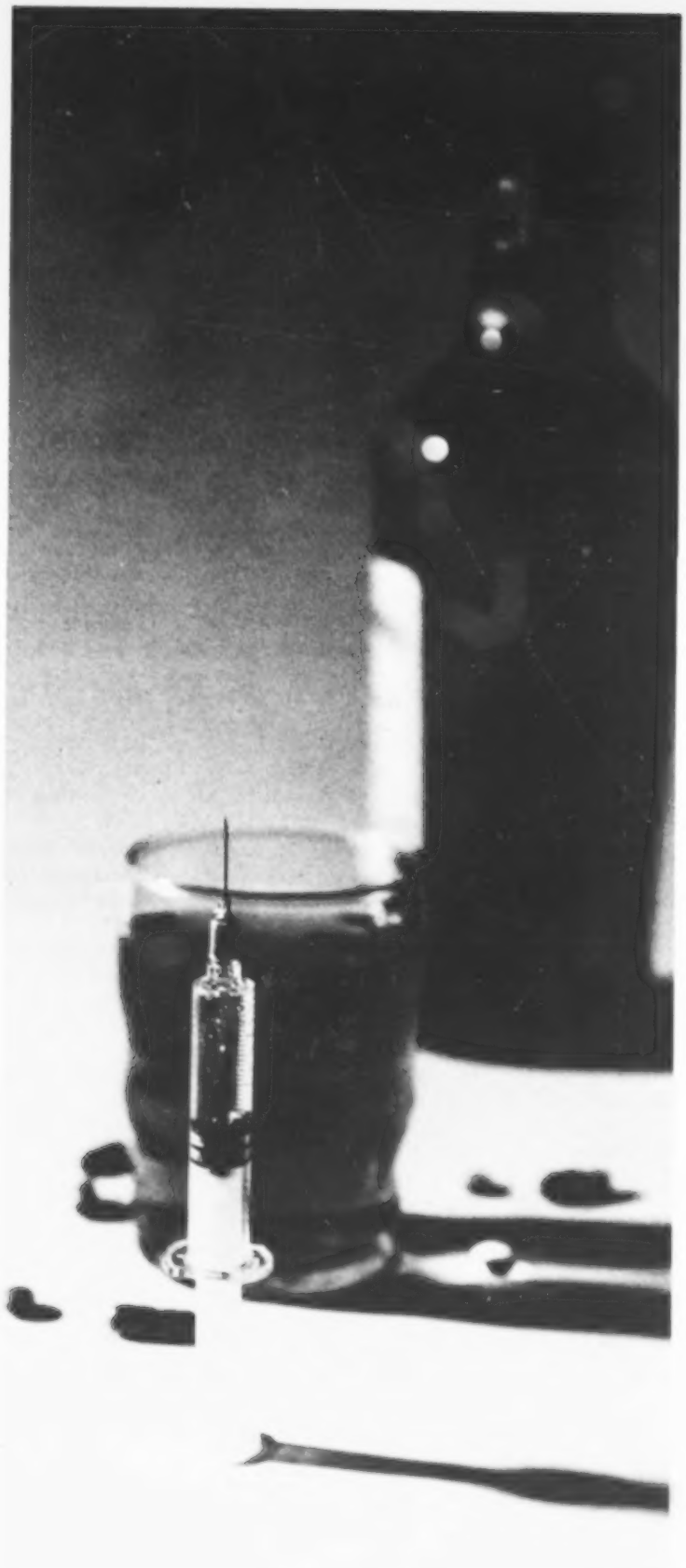
[24]J. H. Jaffe, "Narcotic Analgesics," in L. S. Goodman and A. Gilman (editors), *The Pharmacological Basis of Therapeutics*. New York: The Macmillan Company, 1965, pp. 247–284.

[25]D. P. Ausubel, *Drug Addiction: Physiological, Psychological and Sociological Aspects*. New York: Random House, 1958, p. 23.

[26]A. Bossin, "Daytop Village," *Psychology Today*, December, 1968, p. 51.

[27]For further information concerning these peripheral problems see: D. B. Louria, "Medical Complications Associated with Heroin Use," *International Journal of the Addictions*, 2 (2), 1967, pp. 241–251.

[28]D. B. Louria, *The Drug Scene*. *Op. cit.*, pp. 51–52.



3

DRUGS IN THE HIGH SCHOOL: A STUDENT RESEARCH REPORT*

JAMES VELLEMAN AND THEODORE LAWRENCE

Editorial Note

Following is an example of a student-conducted research project. Four students were involved: James Velleman and Theodore Lawrence, who conducted the survey and wrote the final report, and Bruce Schmid and Daniel Velleman, who programmed the data for the school computer; two teachers (Mr. Cahill and Mr. Bocarde) supervised the students.

This work deserves recognition not only for the excellent research effort and contributions, but also for its applicability to classroom discussion. The students recognized that results of their study must be treated cautiously. Since correlations do not imply a direct causal relationship, there is danger in making interpretations beyond the conclusions already cited. Nevertheless, their procedure, findings, and conclusions are worthy of consideration and replication.

D.J.W.

Introduction

On Tuesday, April 7, 1970, a questionnaire on drug use was administered to the student body of Schreiber High School. The questionnaire asked each student about himself, his friends, his family, his school-

*James Velleman and Theodore Lawrence, "A Student Drug Survey," reprinted from *Schreiber Times*, Vol. 10, No. II, May 13, 1970, Paul D. Schreiber High School, Port Washington, New York. Reprinted with permission of the authors.

ing, his attitudes and his use of drugs. The aim was to find the extent of drug use in the school, and identify certain factors which might be related to drug use. The following pages contain the findings and conclusions obtained from the responses to that questionnaire.

The questionnaire was given to 1416 students. Of those, fourteen refused to answer any sections. Fourteen abstained from one or more entire sections. Five respondents were eliminated because their answers were extremely inconsistent. Seventeen respondents gave slightly inconsistent answers, but only the faulty answers were eliminated.

The students were asked how many times they had used marijuana, LSD, other hallucinogens, amphetamines, barbiturates, and narcotics. The four possible answers to each question were: "Never," "Once or Twice," "3–15 times," and "More than 15 times." If a student chose the first, he was classified as a "non-user" of the drug. If he chose the second, he was called an "experimenter" with the drug. If he chose the third or fourth, he was called a "user" of the drug.

In relating drug use to a number of factors, a means of classifying students as "non-drug users," "experimenters," and "users" without referring to specific drugs was needed. This General Drug Use factor was calculated by classifying each student according to his highest answer on the drug use questions. If a student never answered above "Never," he was classified as a General Drug "non-user." If he answered "Once or Twice" on one or more questions, but never any higher, he was called an "experimenter." If he answered "3–15 times" or "More than 15 times" on any one question, he was classified as a General Drug "user."

Fifty-one percent of the respondents fell into the "non-user" group. Eleven percent were "experimenters" and thirty-five percent were "users." The remaining two to three percent refused to answer drug use questions. These, and all percentages in this report, are rounded to the nearest percent.

The General Drug Use factor was found to perform well in cases where correlations with use of individual drugs were also calculated. The General Drug Use factor did not consistently resemble any one Individual Use factor, but it did reflect the same trend and magnitude of correlation as the majority of the individual factors in cases where they were compared.

It should be noted that while users on the General Drug Use scale comprise nearly 50 percent of the

sample, users of each individual drug, excepting marijuana, constitute small percentages. Correlation coefficients for these single drugs are still valuable in [revealing] trends, but they are more sensitive to each individual in the user category than coefficients calculated with more equally divided groups. For this reason, no conclusion has been based on these single-drug correlations, or on one or two correlations alone.

The associations between use of drugs and the other factors were evaluated by calculating the Yule's Q and Gamma correlation coefficients. The conclusions in this report are divided into the following categories: The Family, Education and Fear, Friends, Potential and Achievement, and Sex and Grade.

There are a number of reasons for our belief that the responses to this questionnaire were a faithful description of the actual facts. Both personal observation and examination of the data indicate that the students answered the questions seriously and honestly.

We believe that the controlled conditions under which the students answered the form were highly effective. Teachers were briefed in advance to be sensitive to the fears of students answering personal questions, and they were instructed so that each would present the questionnaire in the exact same manner. In visiting the testing rooms, we observed a total absence of levity and near total silence. For the few hours directly following the answer period, we spoke to reputed drug users and non-users, friends and strangers alike, and were met with highly encouraging responses. The teacher-proctors who were asked also said that the survey had been treated with great interest and sobriety by the students.

We hypothesized that if the students considered the survey a joke, the extremes would appear inflated in our data. For instance, if an unreasonable number of students had said that both their parents were often drunk, we would have reason to believe that they were exaggerating for the sake of a joke. This was not found to be true.

Of course, some inconsistent answers and pranks were found and eliminated, but the frequency of these was very low.

I. The Family

When this study was conceived, the major hypothesis was that parental drinking, smoking, and pill-taking habits were related to drug use among students. Our

findings substantiate this hypothesis and we can safely conclude that parental habits, or factors related to them, significantly affect student drug use, or factors related to it.

Parent habits which showed the greatest effect were drinking habits, specifically how many drinks the parents have when they drink and how often they are drunk, and pill-taking habits. In some cases the existence of a parental habit, no matter how small, was seen to have an effect. Use of marijuana was least affected by these factors, while use of other drugs showed moderate to substantial effects.

These conclusions were reached through extensive analysis of different approaches to the parental factors. Here, we were especially careful not to rely on any single correlation. Each major conclusion is based on about twenty correlation coefficients, and our final conclusion that parental habits affect drug use is based on over 200 such calculations.

Each student was asked for the following information about each of his parents: how much he smokes; how often he drinks; how many drinks he usually has when he drinks; how many times he has been drunk; how often he takes sleep-related pills; how often he takes tranquilizers. These were questions 16 to 27 on the questionnaire. Each of these habits was compared to drug use in the student through combining mothers' and fathers' habits (Combined factors), and considering only the parent highest in use (Highest Parent factors). Combined factors were correlated with General Drug Use, while Highest Parent factors were compared to use of each drug. Separate mothers' and fathers' Tranquilizer and Drunk factors were also compared to drug use.

A small but definite association between parents' cigarette smoking and student drug use exists. This association was seen between any cigarette smoking by the parents and both General and Individual Drug Use factors.

Of those whose parents smoked at all, 39 percent were General Drug users while only 29 percent of those who had nonsmoking parents were users. This represents a small association ($Q. = 22$). This trend was also observed with use of individual drugs, where correlations were small but definite, except in the case of LSD use where the correlation was moderate. For example, 36 percent of the students whose parents smoked cigarettes used marijuana, while 27 percent of

those with nonsmoking parents did so. The correlation here is small (Q. = 20), as are similar correlations with use of Amphetamines (Q. = 25) and Barbiturates (Q. = 26). Of those with cigarette-smoking parents, 10 percent were LSD users while 5 percent of those with nonsmoking parents used LSD. This represents a moderate association (Q. = 36).

Small association between how often parents drink and drug use exists. Of those whose parents scored high on the Combined factor, 41 percent were General Drug users, while only 30 percent of those who parents scored low used drugs. This represents a small association (Q. = 24). The correlations with individual drugs show the same trend (Qs ranging from .15 for LSD to .3 for Barbiturates).

There is a moderate association between how many drinks parents have and students' use of any drug but marijuana, where the correlation is small. The Combined factor versus General Drug Use calculation showed a small correlation (perhaps because marijuana users constitute a majority of General Drug Users), but correlations with all of the other drugs were consistently and definitely moderate.

Of those who had at least one parent who usually drinks more than one drink, 41 percent used marijuana, while those whose parents scored below that point on the Highest Parent factor were 32 percent marijuana users. This represents a small correlation (Q. = 18). It should be noted that while moderate correlations were found between having one parent who usually drinks more than one drink and use of all other drugs, correlations were usually slightly higher when the line was drawn between those who had at least one parent who drinks more than 2 or 3 drinks and those who scored lower than this on the Highest Parent factor. For example, 16 percent of those who had at least one parent who drinks more than 2 or 3 drinks used LSD while only 7 percent of those whose highest scoring parent drinks less used that drug.

This represents a moderate correlation (Q. = 44). Other Q coefficients ranged from a moderate .33 for use of Amphetamines to .46 for use of Barbiturates.

There is a moderate and significant relationship between having at least one parent who gets drunk with any regularity (once a year or more) and drug use. In fact, those who said that their mothers had ever been drunk had a significantly greater tendency to be drug users than those whose mothers had never been

drunk. This yielded the strongest correlations of any parental habit.

Of those who had, at most, only one parent who had ever been drunk once or twice, 27 percent were General Drug users while 47 percent of those whose parents scored higher on this Combined factor classified as users. This represents a moderate association (Q = .41). Forty-five percent of those whose highest scoring parent was drunk once a year or more smoked marijuana while only 28 percent of those who did not have a parent who was drunk even once a year used the drug. This, too, is a moderate correlation (Q = .35). Correlations with use of the other individual drugs were even stronger than this (Qs range as high as .44 for LSD).

Of those who said that their mother had ever been drunk 44 percent used marijuana while only 27 percent of those whose mothers had never been drunk were users of the drug. This is a moderate correlation (Q = .35). Such correlations were stronger for all of the other drugs (Qs range from .43 for Barbiturates to .45 for Amphetamines). Correlations with the father getting drunk were not as consistently strong as those with the mother, and they were moderate only with increased regularity of drunkenness.

Moderate and significant correlations also exist between having parents who use any tranquilizers or sleep-related pills and drug use. The latter are any pills used to go to sleep or to keep awake. Combined factors versus General Drug Use and Highest Parent factors versus use of each individual drug except for marijuana showed moderate correlations. The association with marijuana use was small.

Fathers who use tranquilizers with any regularity (more than about 5 times a year) yielded the stronger correlations than mothers' use of tranquilizers.

Of those whose parents used any tranquilizers, 46 percent were General Drug users, whereas only 29 percent of those whose parents never used tranquilizers were users. The percentages for Combined Parents use of sleeping pills versus General Drug Use are identical. These represent moderate correlations (Q = .34 for both). Nearly as strong associations were found between regular use of tranquilizers and sleep-related pills and drug use (Q = .33 and .31 respectively).

This trend was substantiated in the correlations with use of individual drugs. The exception was use of marijuana, where correlations were only small (Q = .28 for tranquilizers and .27 for sleep-related pills). Com-

paring to use of Barbiturates, 5 percent of those whose Highest Parent did not use sleep-related pills regularly were users, while 11 percent of those whose parent used pills regularly were Barbiturate users. Of those whose highest scoring parent used tranquilizers regularly, 15 percent used Barbiturates, while only 9 percent of those whose Highest Parent did not regularly use tranquilizers were users of the drug.

Correlations with fathers' use of tranquilizers, except the one for use of marijuana, were between Q=.35 and Q=.45. For mothers' use, however, coefficients were negligible to small, with one in the moderate range.

It would be irresponsible to conclude from these findings that parental habits "cause" drug use among students. It is possible, for instance, that the two phenomena have a common cause and that they are related through this third factor.

However, we believe we can safely conclude that parental habits or factors related to them affect student drug use or factors related to it.

Certain factors in the family life of each student were compared with drug use. Small associations between drug use and discord in the family were found.

The students were asked whether their parents were living together, separated, or divorced. In calculations, the latter two were combined into a "separated parents" category. The students were also asked how often their parents fight or quarrel. This question unfortunately had a high rate of abstentions. These were questions 12 and 28 on the questionnaire.

It was found that 44 percent of those whose parents were either separated or divorced were General Drug users, while 35 percent of those whose parents live together were users. This represents a small association (Gamma=.21).

Of those who said that their parents fought with any regularity (more than "once or twice that I can remember") 42 percent were General Drug users whereas 30 percent who said that their parents had quarreled only "once or twice" or less were in the user group. This, too, can be said to represent a small correlation (Q=.26).

II. Friends

An examination of a student's friends using drugs as compared to his own drug use leads to two basic conclusions. Drug users strongly tend to have friends

who are also drug users, and some type of peer pressure is strongly related to a student's drug use.

Separate correlations of drug use versus friends' drug use were made using people who answered "Yes" and "No" to question 8, which asked if the student's group of good friends was the same general group as the people who were his friends in ninth grade. If a student answered "Yes" (kept the same friends), one can safely conclude that if his good friends started using drugs, he must have been in some way influenced to use drugs. By the same token, if he started using drugs, then he must have, to some extent, influenced his friends to use them. In either case, peer pressure is exerted.

Correlations involving students whose friends remained the same between drug use and friend drug use were the strongest of the entire survey. Of the students whose friends since ninth grade were non-users or experimenters with marijuana, only 6 percent used the drug, while 70 percent of those whose friends use marijuana were users (Q=.95). (In a perfect correlation, such as the chances that when you jump up, you will come down, Q equals 1.) This same extremely strong correlation is found with LSD, where 53 percent of those whose friends have ever tried this drug had tried LSD, while only 2 percent of those whose friends had never tried LSD had ever taken this drug (Q=.96).

All correlations of friends' use of drugs versus student drug use, regardless of the answer to question 8, yielded extremely strong relationships between friends who use drugs and the person who has these friends using drugs (Qs ranging from .89 to .96). Therefore, we can conclude that drug users tend strongly to have friends who use drugs, and that peer pressure is in some way strongly related to a student's drug use.

III. Education and Fear

Relationships between drug education, fear of drugs, and drug use were explored. It was found that while users of a drug tend to fear that drug significantly less than non-users and experimenters, drug users in general do not differ from others in fear of the law. We cannot conclude whether lacking fear of a drug causes use, or use of a drug causes loss of fear. However, we can state that the law does not serve as a deterrent to drug use.

Each student was asked whether or not he had completed the school Health course, seen school assemblies about drugs, or visited the Nassau County Mobile Drug

Display (Questions 5–7). In addition he was asked to agree or disagree with 12 statements about the physical and psychological dangers of marijuana, LSD, and heroin and legal dangers of using drugs (Questions 29–40). Total "scores" for fear of each drug and fear of the law were calculated for each student. In order to calculate percentages, a median score was found for each factor, and the sample was split into approximately equal "high" and "low" fear groups.

Sixty-one percent of the non-users and experimenters with LSD scored High on fear of that drug whereas only 19 percent of the users scored High (questions 30, 34, and 38). This represents a very strong association between lack of fear and use of LSD Gamma = .71). Of the marijuana users, 28 percent scored High on fear of marijuana, while 66 percent of the nonusers and experimenters did so. This also shows a strong association between lack of fear and use of marijuana (Q = .02, Gamma = .44). Heroin users were so small a group that calculations of fear versus use of heroin would have been of doubtful value.

Nearly equal percentages of General Drug users and non-users scored High on fear of legal dangers (questions 31, 35, and 39). Forty-six percent of the non-users and experimenters and 46.2 percent of the users were in the High fear group. This represents a negligible correlation (Gamma = .02).

Drug education efforts in the school were found to have a very small effect on both fear and use of drugs. In other words, those who had received drug education did not use drugs any less or fear them significantly more than those who had not. These findings apply only to Juniors and Seniors, since they are the only students who have received drug education at Schreiber.

Of those who had completed the Health course, 41 percent were found to be drug users on the General Drug Use scale, while 39 percent of those who had not completed Health fell into the User group. The fact that these percentages are nearly equal demonstrates the lack of an effect of the Health course on General Drug Use (Gamma = .06).

Correlations between participation in Health and use of the individual drugs were negligible (Gamma's ranging from .04 for Narcotics to .08 for LSD). It might be argued that a student who had used drugs and then been convinced to quit by the Health course would score as a Health student who used drugs. This is because the drug use questions asked how many times (as opposed to

how often) the student had ever used each drug. However, if the Health course did, in fact, convince students not to use drugs, non-users would have been discouraged from becoming experimenters, experimenters discouraged from becoming "3 to 15 times" users, and people in that category discouraged from progressing to the "More than 15 times" group. This trend was not found. In fact, if there is any tendency at all, it is a negligible one for Health students to be users.

Likewise, it was discovered that drug assemblies do not diminish use. However, here was a moderate relationship demonstrating that those who visited the Drug Module tended to be users. Since the Module was the only voluntary form of drug education included in the survey, we can conclude that those who visited the Module tended to be users because drug users had a greater interest in it.

Of those who had seen drug assemblies, 52 percent were Control Drug users while 30 percent of those who had not seen it that category (Gamma = .31). At the same time, 44 percent of those who visited the Module were users, while only 39 percent of those who had not seen it the User group (Gamma = .07).

Negligible or no correlations were found between participation in drug education and increased fear of drugs. Fifty-two percent of those who had taken Health scored high on fear of marijuana while 51 percent of those who had not taken Health scored in that range. This represents a negligible relationship (Gamma = .03). Nearly equal percentages of 57 for Health students and 56 for non-Health students scored high on fear of LSD. This too shows a negligible relationship (Gamma = .02). However, fear of heroin had a low correlation with participation in Health, with percentages of 70 for Health students and 48 for non-Health students scoring high. The correlation here is small (Gamma = .11). These findings also apply only to Juniors and Seniors.

Fear of drugs was correlated with a continued factor of Assemblies and Module. Negligible associations were found for each of these (Gammas below .07). It is possible that these findings were affected by the fact that viewers of the Drug Module tended to be users. Further calculations would be necessary to determine whether or not this is the case.

Thus the following conclusions can be made. Users of a drug tend to fear that drug significantly less than non-users and experimenters. Control Drug Users do

not differ from others in fear of the legal dangers of drugs; Drug education has a negligible effect on drug use; the Health course has a negligible effect on fear of drugs, except in the case of fear of heroin, where the effect is small.

IV. Potential and Achievement

Academic potential, class standing, and under- or over-achievement were compared with General Drug Use. It was found that drug users have a small tendency to be higher in potential, a negligible tendency to be lower in class standing, and a small to moderate tendency to under-achieve more than experimenters and non-users. These findings apply only to Juniors and Seniors.

The academic potential of each student was measured by his score on the Verbal P.S.A.T. examination (question 4). Statistics reporting how many people had achieved each score had been obtained so that the answer choices on the survey would split each class approximately into fifths. The academic achievement of each student was measured by class standing, which also divides each class approximately into fifths (question 5). A rough estimate of whether each student achieves below his potential, above his potential, or at the same rate as his potential was obtained by comparing the two quintiles within which he fell. By subtracting the number of his quintile in standing from the number of his quintile in potential, a zero was obtained if he achieved at the same rate as his potential, a positive number if he under-achieved, and a negative number if he over-achieved. An unfortunate result was that, whereas about 200 people fell into each of the top four-fifths in standing and potential, the lowest fifth on both scales was very small. It is possible that a great number of students in these lowest categories abstained from questions 3 and 8, or were absent. If so, the correlations would not be affected. Otherwise, this is a possible source for error.

Of those who are in the top two-fifths on their Verbal P.S.A.T., 88 percent were found to be General Drug users, while 76 percent of those in the lower three-fifths were classified as users. This demonstrates a small association between high potential and drug use (Gamma = .16).

Of those who are in the top two-fifths in class standing, 87 percent were found to be users, while 81 percent

of those in the lower three-fifths were so classified. This demonstrates a negligible association between low class standing and drug use (Gamma = .09).

The zero group—the group of people who achieve at the same rate as their potential—was 40 percent General Drug users. Under-achievers were 49 percent users and the over-achievers only 30 percent users. The differences in these percentages represent a small association between drug use and under-achievement (Gamma = .24).

A different method of analyzing these results was to eliminate the zero group, and comparing only under-achievers to over-achievers. Here, the correlation between under-achievement and General Drug Use was moderate (Q = .4).

Of course, it cannot be concluded from these findings that drug use causes under-achievement. A third factor may cause both use and under-achievement. Or, under-achievement may cause use.

Thus, we conclude that drug users have a small tendency to be higher in potential than experimenters and non-users, and a small to moderate tendency to under-achieve.

V. Sex and Grade

Each student was asked for his sex and grade. There were questions one and two on the questionnaire.

A moderate to small, and sometimes negligible, tendency for drug users to be males was observed, except in the case of amphetamine and barbiturate use, where there is a negligible tendency for users to be females. In General Drug Use, 57 percent of Schreiber's males were users while 38 percent of the females fell into that category. Twelve percent of the males and 10 percent of the females were experimenters. The fact that these percentages are so nearly equal shows that the relationship between General Drug Use and sex is negligible (Gamma = .09).

In the cases of marijuana, LSD, other hallucinogens, and narcotics, there were small to moderate tendencies for users to be males. For example, 10 percent of the males in the sample were users of LSD, while only 3 percent of the females were users. This represents a moderate relationship (Q = .55). Weaker associations between the sex and the other three groups of drugs were found (Gammas range from .15 for marijuana to .41 for hallucinogens).

In the cases of amphetamine and barbiturate use, negligible tendencies for users to be females were found. Seven percent of the females were barbiturate users while only 5 percent of the males were users (Gamma = .06). Ten percent of the females used amphetamines, while 9 percent of the males did so (Gamma = .02).

Students in higher grades had a greater tendency to be drug users. The association between grade and use, however, is small. In General Drug Use, 44 percent of the Seniors were users, while only 36 percent of the Juniors and 27 percent of the Sophomores were in that category (Gamma = .23).

Small relationships between use and grade were found for hallucinogens, marijuana, LSD, amphetamines, barbiturates, and narcotics use (in descending order; Gammas range from .25 to .16).

VI. Conclusion

The findings of this study are not absolute truths and further research is always warranted. However, these findings indicate the need for a drastically revised attitude towards drug use on the part of the entire community.

Our findings indicate that the parents are far more deeply implicated in the problem of drug use than the present attitude admits. Parents can no longer be considered spectators of the drug problem but are a major part of it themselves. There are strong indications that the students themselves have the power to reduce drug use in their midst. We would recommend that the bulk of further research be concentrated in this area.

A first step to any remedy is the full realization that school efforts in their present form are worthless. Present drug education leaves almost no impression on the students.

The law is equally as ineffective in curbing drug use. Our findings lead us to believe that efforts must be directed away from legal intimidation and towards the family and peers if the drug problem is ever to reach a solution.

4

EXCESSIVE DRUG USE: SIGNS, SYMPTOMS, AND FAMILY-RELATED FACTORS

DONALD J. WOLK

> Drug abuse is an act; a behavior; and as such should be fully investigated and understood by the students. The reasons for one's actions, therefore, should become an important part of drug education with its focal point being an understanding and appreciation of the self.[1]

Excessive drug use is usually symptomatic of emotional difficulties related to self, family, school, and/or one's social relationships.[2] The primary goal of drug users is relief from a painful existence, or, as Berg stated:

> Contrary to claims of indescribable delight by some drug takers, most people abuse drugs to relieve anxiety. They're not pursuing pleasure, they just have less an drugs.[3]

To present drug abuse as a sign of deep emotional disturbance—implying need for psychiatric care—may be worthwhile with an interested group. However, an excessive concern is then focused on an area that could be threatening to some youngsters, causing them to become defensive and to deny (to themselves and others) that they have "psychological hangups."[4] With most youngsters it is far more beneficial and less threatening

to examine concrete, everyday behavior, and to help them explore better methods of handling their personal and inter-personal problems.

This short chapter will focus on three areas that relate to drug abuse:

A. General signs and symptoms resulting from excessive drug use,

B. Signs of drug abuse related to specific drugs,

C. Some predisposing family-related factors leading to drug abuse.

The reader will be familiar with some of the factors as causes or manifestations of emotional difficulties in non-drug users.

A. **General signs and symptoms resulting from excessive drug use.** Although excessive drug use often emits negative side effects, abusers frequently ignore these symptoms—or rationalize them as insignificant, compared to "benefits" derived from the drug. Nonetheless, these danger signals should not be overlooked by the user, his friends, or his teacher:

(1) *Problems in concentration.* Inability to pay attention to instructions or to complex tasks. Drug user's mind wanders or is too unsettled to work, resulting in increased difficulty in problem-solving tasks, schoolwork, homework.

(2) *Failing memory.* The individual evidences careless thinking—sudden gaps in recall of relatively simple items. Embarrassment or anxiety may lead him to fabricate substitute material.

(3) *Decreasing ability to communicate thoughts and feelings.* Increased belief that "others do not understand me" (especially those who are "straight"—those who do not use drugs). May lead to poorer interpersonal relationships with parents and close peers, depressive moods, or defiant ("I don't need others!") attitude.

(4) *Exaggerated self-confidence,* especially noted in daily performance (classroom, tests, homework) where there has been either no change or even decreased efficiency.

(5) *Feelings of inferiority and inadequacy increase.* Facility about the person and future is followed by nervousness and depression.

(6) *Sudden or progressive apathy,* loss of energy, desire to perform, or to become involved. Individual appears "lost in space," indifferent, disinterested

(7) *Greater impulsivity*, erratic behavioral tendencies (unexplainable and seemingly irrational performance, sudden irritability, explosive outbursts); unpredictable mood swings, from happiness and contentment to depression or anxiety—and back.

(8) *Paranoid attitudes*. Suspiciousness, feelings of persecution, (belief that people or institutions are hostile to him, personally). A growing distrust of friends, teachers, parents.

(9) *Denial* of harmful effects of drugs on *him*. Strong desire to try other, more potent drugs, especially if one is still dissatisfied or depressed.

(10) An expressed *wish to "freak out,"* i.e., to have a psychotic reaction to drugs, so as to necessitate hospitalization.

B. **Signs of drug abuse related to specific drugs** (while under the influence of the drug):[4]

(1) *Marijuana*. Users may stare into space and appear glassy-eyed or dreamy. They may drift into a brief semi-conscious (sleep-like) state or may reveal a sudden, momentary "rush" (their attention is suddenly diverted; they may close their eyes, shudder, appear dreamy or distant). However, it is difficult to spot the experienced marijuana user as he knows how to "handle" himself and the effects.

(2) *Hallucinogens* (LSD, mescaline . . .). Behavior may be totally irrational or bizarre. Individual may appear to have a psychotic episode (hallucinating, delusional, etc.). Sudden mood swings, ranging from unusual joy and unexplainable loud laughter to uncontrollable sobbing, to deep, silent or moaning depression. Person may act extremely lost and confused while being verbally uncommunicating.

(3) *Amphetamines* (stimulants, "ups"). Unusual increase in physical activity and talkativeness, restlessness. Exaggerated cheerfulness, hand tremors. When coming down from the drug, one may expect marked fatigue, increased "nervousness," depression.

(4) *Barbiturates* (sedatives, "downs"). Individual (*under heavy dosage*) may appear intoxicated, but with no odor of alcohol. He will seem sluggish, gloomy, perhaps quarrelsome and irritable. Speech may be slurred, physical coordination will be uncertain and unsteady.

(5) *Glue*, gasoline, paint thinner, lighter and cleaning fluids, etc. (*Users may appear intoxicated* (similar to heavy barbiturate use; see above). They may

appear distant and dreamy or surly and belligerent. Nausea may be suffered.

(6) *Heroin.* Users will appear dazed or sleepy ("nodding"); stare into space or drift into sleep. Ability to concentrate is impaired as attention strays from subject.

Although the above information is of importance in spotting drug use, teachers need not be as alert to specific drug symptoms as to signs of disturbed or maladaptive behavioral patterns. The focus of concern must be on the student-as-person, not on the student-as-drug user. Being sensitive to and acknowledging individual difficulty or unexplainable, self-defeating behavior tendencies in one's students is crucial for the teacher—if he intends to do more than convey curriculum content.

C. Studies of heroin addicts,[3] chronic glue sniffers,[4] and intensive drug users in general,[5] reveal several **major family-related factors leading to drug abuse.** These factors are summarized as follows:

(1) Family disorganization, especially discordant parental relationships. The marital relationship is unstable or precarious; an atmosphere of confusion, tension, and hostility is experienced by the child. Homes which lack warmth and cohesion, where parents are separated or divorced, are significant factors leading to drug problems.

(2) Vague or inconsistent discipline and standards. Parents are either unclear or ambivalent as to child rearing, fluctuating from over-indulgence to strict authoritarian discipline (or one parent constantly countervails the other).

(3) Rigid, arbitrary, authoritarian discipline and behavior standards, not balanced by understanding, compassion, or individual attention.

(4) Parents (one or both) serve as "models" for deviant behavior patterns. For example, mother, father, or both may be heavy drinkers (or alcoholics), sexually promiscuous, drug abusers, etc.

(5) Poor father-son relationship. Father is either physically absent from home (with no father substitute available), or he is emotionally detached. Father may then be perceived (by son) as uninterested or disinterested, offering little or no warmth or affection.

Conversely, the relationship may be one in which the father is predominantly hostile and punitive, caring little for the boy's nurturant needs. Identification with this

type of father is extremely difficult, even threatening. The result: a confused, ambivalent image of oneself as an adequate male. This is most notable in homes where mother is also perceived as the primary parent during early and later childhood years, *or* where mother-child relationships are also poor.

Other family-related situations, such as mental illness and antisocial behavior displayed by parents and/or siblings, predispose youngsters to abuse drugs. Perhaps an awareness and understanding of some of the motivating causes for drug abuse, plus explanations of alternative avenues of finding oneself (or of "turning on"), will aid in reducing excessive drug use.

FOOTNOTES

[1]*The Stamford Curriculum: A Study Guide to Help Schools and Teachers Combat the Drug Epidemic*, Stamford Public Schools, Stamford, Connecticut, January, 1970.

[2]Excessive drug use (or abuse) is here defined as the self-administration of excessive quantities of drugs, leading to tolerance, physical and/or psychological dependence, mental confusion, and other symptoms of maladaptive behavior. This definition was partially adapted from: "Dependence on Barbiturates and Other Sedative Drugs," prepared by the A.M.A. Committee on Alcoholism and Addiction [now referred to as Drug Dependence], *Journal of A.M.A.*, August 23, 1965, 193, pp. 673-677.

[3]R. H. Berg "Why Americans Hide Behind a Chemical Curtain," *Look magazine*, August 8, 1967, pp. 12-13.

[4]Partly adapted from "A Schoolman's Guide to Illicit Drugs," *School Management*, June, 1966, pp. 100-101.

[5]See: I. Chein, *et al.*, *The Road to H*. New York: Basic Books, Inc., Publishers, 1964.

[6]See: E. Press and A. K. Done, "Solvent Sniffing," *Pediatrics*, 39, Nos. 3-4, March and April, 1967.

[7]See: R. H. Blum and Associates, *Students and Drugs*, (Drugs II). San Francisco: Jossey-Bass, Inc., Publishers, 1969.

5

SOCIAL AND POLITICAL ASPECTS OF DRUG USE*

GEORGE R. EDISON

Editorial Note

Are individuals of a certain political persuasion more apt to take drugs?

Are drug users freethinkers, flexible and liberal in views and behavior, or are they escapists from an intolerable and depressing social scene?

The problems of society, as Lasswell states, "do not lie solely in disintegrating family units or permissive education and parents. Especially over the last few years we have become more and more a militaristic society. The leadership of the country at municipal, state and national levels is clearly dominated by men of limited ability and restricted imagination, who lack the capacity to envision an aura of vigor or of important accomplishment.

". . . the overall image presented by both major political parties is an unfortunate combination of anachronism, ineptitude, mediocrity, self-interest and, worst of all, an inability to deal with the major problems of our time. One can dispute this interpretation, but not the fact that it is largely believed by our young people."[1]

[1] Presented before the General Session, American College Health Association, Thirty-seventh Annual Meeting, Oklahoma City, Oklahoma, April 12, 1969 by Edison, George R., Director, Counseling Health Service, The University of Utah, Salt Lake City, Utah. See Course 8, Edison, "Social and Political Aspects of Drug Use." Used with permission from Mr. George R. Edison, College Health Association Vol. 18 No. 5 March-April 1970, pp. 274-277.

Drug use, according to Blum, is significantly associated with one's political position.[2] His studies of college students on five different campuses yielded that drug users were represented strongly by those within the left and radical-left political spectrum. The very conservative, the Republicans, and independent-conservatives were "under-represented," concerning the use of drugs. The only exception to this was a "high" use of sedatives by the very conservative.

Another related finding concerned students' agreement or disagreement with their parents' political position. Students who were aligned with their parents reported the least amount of drug experience; "students in [political] disagreement with both parents report the highest proportion of drug experience for all drugs but sedatives . . ."[3]

The following research article explores one aspect of the political-social dimension of drug use. It is of special interest for the social studies class.

D.J.W.

Those of you concerned about drug use and abuse know that young people turn on for many reasons: pleasure seeking, relief of boredom, tension or depression, self-destruction, rebellion, peer group pressure, and the search for self, among others.

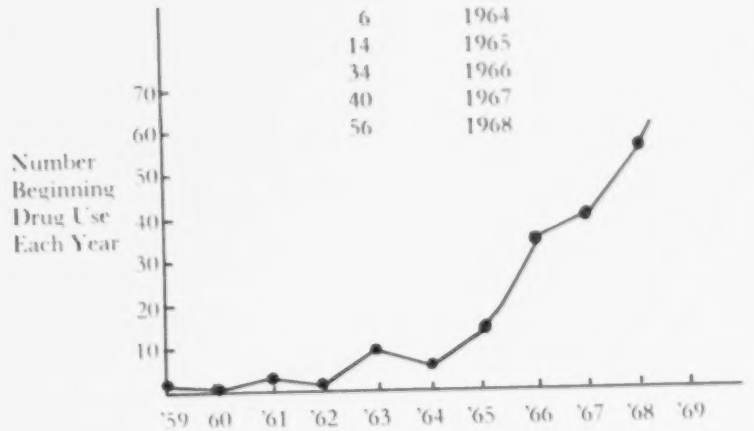
Valid though these may be, they leave a lot unexplained. They do not really tell us why large numbers of young people are repeatedly flaunting the law, jeopardizing their futures and exposing themselves to substantial risks, or why there has been such a startling increase in drug abuse in the last five years.

Figure 1 shows the year in which illegal drugs were first used by the individuals in our study. This curve could just as easily represent drug arrests or hospitalizations for drug-induced psychoses. Curves like this are open to question, both methodologic and substantive. Drug use is certainly not a recent phenomenon. But, despite the fact that society is more sensitive to the drug issue, the police more active, and the reporting of drug use more reliable, I think most of us regard this increase as a real one, and wonder why.

Looking at the problem epidemiologically, we get interested in three factors: the agent, the host and the environment. The agent really has not changed much over the years. Amphetamines and LSD are youngsters in their thirties, but most of the others have been around for several thousand years. Human body and

FIGURE 1. Year of first illegal drug use.

Began Drug Use	*Year*
1	1959
0	1960
3	1961
1	1962
9	1963
6	1964
14	1965
34	1966
40	1967
56	1968



brain chemistry is about the same as it was centuries ago, so the host seems to remain fairly constant.

What we most need to study in the epidemiology of drug use is the environment, and those things about the environment which promote psychological disturbance in large numbers of young people, and which allow them to feel that the use of drugs has more advantages than disadvantages.

What is this environment? I see it as the total social and political structure of the country. Out of this environment we could select many areas which might theoretically influence drug use in young people, from poverty and minority group oppression to the exploitation of our natural resources and pollution of our waterways and atmosphere. (The imagery of this last example is especially evocative as we deal with the pollution of bodies by drugs.)

We have chosen in this study to focus on the war in Viet-Nam. The reason is clear from Figure 2 which depicts American troop commitment in Viet-Nam. Figure 3 simply superimposes the curves shown in Figures 1 and 2.

Side by side, then, two national crises have developed in scope and intensity over the same five-year period. Is there a relationship between them? If so, how do they influence each other? To study the problem we formulated a "Social Issues Survey," a questionnaire probing attitudes and knowledge about drugs, dealers,

FIGURE 2. Commitment of American troops in Viet-Nam

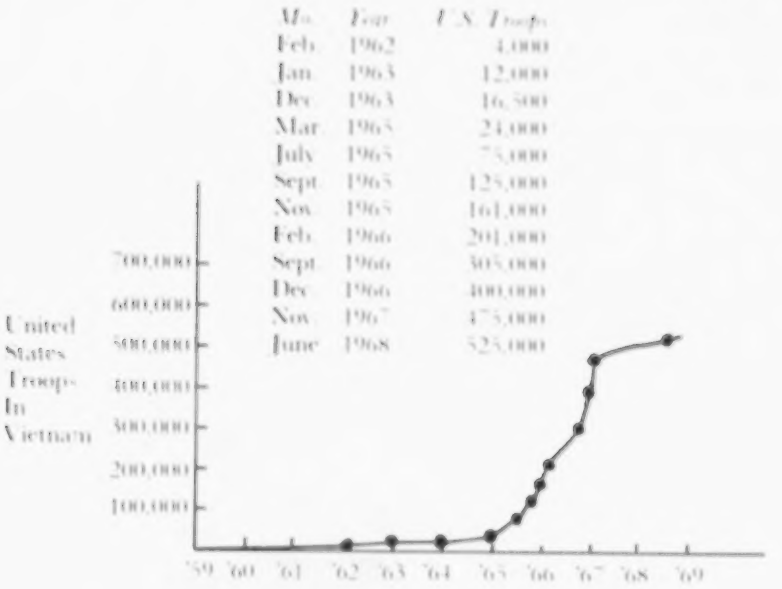
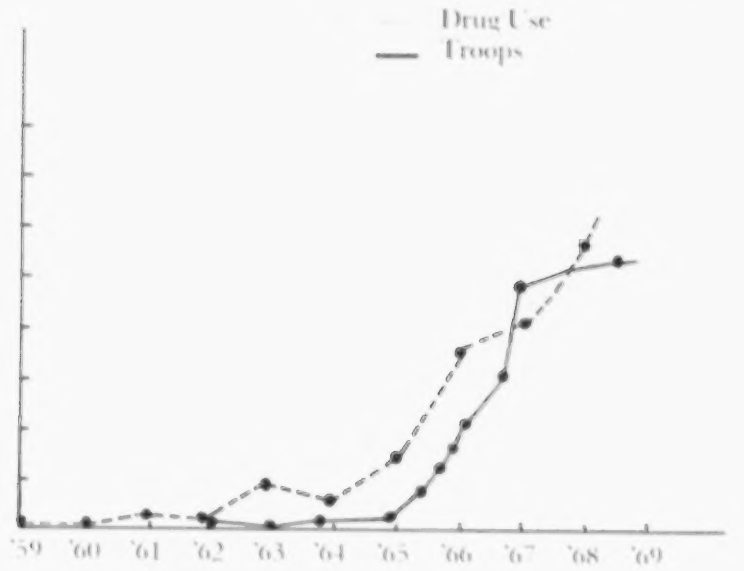


FIGURE 3. Drug usage compared with American troop commitment



the war, the Viet-Cong, and the United States position in Viet-Nam.

We submitted this survey in March and April of 1968 to 135 drug users and 302 nonusers, selected in a variety of ways. Bearing in mind that this is an unsophisticated pilot study, these are some of the results, many of which you have undoubtedly predicted.

Table 1 describes the study group. Males predominate, especially among users, who also tend to be slightly younger than nonusers.

Table 2 compares the feelings of users and nonusers about the war. Users were strongly against the war and held dovish views of what we ought to do about it, while nonusers were more evenly divided.

Table 3 compares the views of users and nonusers toward both the United States position in Viet-Nam and the university's position toward drug use. These are not surprising results if you assume the United States and the university both represent authority and establishment. The drug user rebels against it, while the nonuser identifies with it.

Table 4 shows the converse, the views of each group about the most rebellious segment in each situation. As can be seen, users felt rather positively toward both. The surprise here is the rather accepting attitude toward the Viet-Cong on the part of even nonusers.

What do these results mean? I think they support the following notions.

The war in Viet-Nam has caused a crisis of national conscience, principles and goals. The consequent frustrations and debate are forcing our country to a major inward look and re-evaluation. They magnify the adolescent's normal sense of alienation. When grave questions are raised about our country's moral and legal position in a war, young people find it difficult to maintain confidence in our moral and legal codes in areas closer to home.

The war and the drug scene demonstrate a striking parallel in the disposition of the belligerent forces. Viet-Nam presents underdog rebels fighting a formidable military establishment, while caught in the middle are most ordinary Viet-Namese, apparently uncommitted. Back home in the drug war we find the same three elements—rebellious drug users clashing with conservative establishment forces, while neutral nonusers hold the middle ground and try to protect both their reputations and their civil liberties.

Undoubtedly there is a spiritual kinship among rebels everywhere. But these are no ordinary bonds that link the Viet-Cong rebels and the rebels of the drug scene. What we must understand, and what this discussion is really about, is that the entire Viet-Nam scene provides the drug user with an ideal model for unconscious identification. In his use of drugs he can share both the exhilaration and the agony of the Viet-Namese. He recreates their experience in microcosm.

At an age where rebellion, a sense of moral outrage, and the need to establish identity and independence are

TABLE 1. Age, sex and drug use history of study subjects

Total sample	437	
Users	135	(25 no longer using drugs)
Nonusers	302	
University students	347	
Nonuniversity students	90	
	Users (%)	*Nonusers (%)*
Male	67	56
Female	31	40
Age		
14–15	3	0
16–17	16	2
18–19	34	29
20–21	14	31
Over 22	33	39

TABLE 2. Attitude toward Viet-Nam war

	Users (%)	*Nonusers (%)*
Opinion of war		
Pro	7	45
Anti	78	37
Hawk — Dove		
Hawk	5	42
Dove	63	22

TABLE 3. Attitudes toward U.S. position in Viet-Nam and university position on drugs

	Users (%)	*Nonusers (%)*
U.S. position in Viet-Nam		
Pro	7	50
Anti	75	30
University position on drugs		
Punitive	7	68
Permissive—Educational; University should take no position	83	31

TABLE 4. Attitudes toward drug dealers and Viet-Cong

	Users (%)	*Nonusers (%)*	*Former users (%)*
Opinion of drug dealers			
Negative	34	90	60
Positive	40	1	24
Neutral	22	4	8
Opinion of Viet-Cong			
Negative	20	37	
Positive	50	43	
Communists primarily	15	37	
Nationalists primarily	57	42	
Do not admire them	32	47	56
Admire them	63	48	44

the norm, he becomes aware of the Viet-Namese peasant, a man of small stature and dark skin, living in a primitive agrarian culture, a little man who has been struggling for independence for centuries from a succession of giant foreign protectors. This Viet-Namese is almost a prototype underdog. His nonwhiteness reawakens all of the American student's concerns about the persecution of minority races. It becomes simple for him to transfer his cathexis from our civil rights struggle to the war in Southeast Asia.

Even the religion of the majority of Viet-Namese lends itself to unconscious identification. The spectacle of Buddhist Viet-Nam subjected to systematic destruction by industrialized wealth crystallizes many a young American's rejection of his country's less noble qualities, its materialism, its militarism, its self-righteousness and aggressiveness. Through drugs he can reflect, discard society's crass traits, and approach the kind of reconciliation with reality that Eastern religions teach. At the same time he can assuage guilt.

Observe also the communion between the two rebel groups in the identity crisis of the drug users and of the country Viet-Nam (even now unsure whether it is one or two nations), in the evasive guerrilla game both drug user and Viet-Cong play, and in the risks that both take to achieve their goals. Educational programs designed to warn about the hazards of drug use are seriously compromised to whatever degree the individual's decision to use or not to use drugs is not based on rational thinking. If his behavior is significantly motivated by an unconscious identification with the Viet-Namese and the Viet-Cong, who are almost daily risking personal and national destruction, education can have only limited value.

Finally, a brief comment about the features common to the establishment response in both wars. We see a disconcerting similarity in war aims. The earliest one in each case is limited, innocuous, and totally acceptable to the public, purporting to help people victimized by ignorance and inexperience and based on the assumption of a vicious and aggressive enemy which cannot be resisted by its weak victim. Through a series of errors and miscalculations the aims and commitment gradually escalate. Goals become confused. We are not sure what we are fighting, or why. In our effort to help people we find ourselves destroying them.

Yet it may turn out that the most devastating effects of our massive intervention in Viet-Nam have been on

our own society, torn apart as never before. We seem unable to win because we can hardly define the enemy, much less our goals. Likewise, in the drug war, we the establishment strike out with heavy artillery at all kinds of targets—dealers, heavy users, experimenters. The most obvious effect of this bombardment is on us. We have become very "uptight," while not really reducing drug abuse.

What tentative conclusions might we draw from this new dimension on drug abuse?

1. Social and political situations exert a powerful influence on drug use in young people.
2. A current situation of major importance is the Viet-Nam war.
3. The specific link between the war and drug use is the unconscious identification model which the Viet-Cong provide for drug users, and which the establishment position in Viet-Nam offers the establishment at home.
4. If we really want to curb drug abuse, we must deal with the relevant social issues and, as one example, we might heed the lessons learned in Viet-Nam.

FOOTNOTES

[1] D. B. Louria, *The Drug Scene*. New York: McGraw-Hill Book Company, 1968, pp. 24-25.

[2] R. H. Blum, "Student Characteristics and Major Drugs," in R. H. Blum & Associates, *Students and Drugs—Drugs II*. San Francisco: Jossey-Bass, Inc., Publishers, 1969, p. 70.

[3] *Ibid.*, p. 72.

6

SOCIO-LEGAL POLICIES ON DRUGS*

WILLIAM H. McGLOTHLIN
AND LOUIS J. WEST

Editorial Note

The steadily increasing use of legal and illicit drugs has created controversy about contemporary drug laws. Opinions range from increasing the severity of drug laws, to reform, and finally, to the abolition of laws concerning marijuana. Existing legislation has been flouted; police authorities work overtime to reduce "criminal" activity; judges are reluctant to impose sentences which they find inequitable and, therefore, deplorable.

Marijuana, in particular, has become the subject of on-going debate. Proponents of strict drug laws argue that marijuana leads to other drugs; that youngsters who are confused in their search for an identity are prey to additional and unnecessary turmoil through drug use. Moreover, marijuana is alleged to be a passivity-inducing drug—one which will serve a negative purpose in our active, productive American society. Legalization of marijuana would add one more intoxicant to the market. The freedom of the individual must be subordinated to the good of the society.

Those who would legalize the drug counter these arguments by citing the opinion that marijuana is a relatively mild intoxicant, physiologically safer than alcohol. In a majority of cases it does not lead to hard drugs, and it does not produce long-term physio-

*William H. McGlothlin and Louis J. West, "The Marihuana Problem: An Overview," reprinted from the *American Journal of Psychiatry*, September, 1968, Vol. 125, pp. 370-378. Copyright 1968, the American Psychiatric Association.

logical or psychological impairment. Moreover, the individual's right to choose his life style—as long as it does not infringe on others—is a basic and necessary freedom.

The arguments reverberate across the nation, in the halls of Congress, and between the generations.

In the following article, the authors explore social and legal attitudes and policies regarding the use of psychoactive drugs. They hold the opinion that reappraisal of current social and legal policy is necessary in order to resolve the drug dilemma.

D.J.W.

The combination of a very rapid increase in marihuana use and the severe penalities prescribed for violation of the marihuana laws has brought about a social crisis. These two phenomena are not necessarily independent. The extreme legal penalties and the gross exaggerations of the consequences of marihuana use as fostered by the Federal Bureau of Narcotics make it an ideal target for rebellious youth to point to as an example of adult hypocrisy.

. . . Social policy with respect to marihuana and other psychoactive drugs has many important dimensions. . . . The most basic issue is whether or not the prohibition of behavior whose direct effects are limited to the individual is within the function of the state. Those who feel it is not argue that the state has no more right to intervene with respect to the use of harmful drugs than it does with regard to harmful overeating.

Those who take the contrary position argue that the harms are not limited to the individual but burden society in a variety of ways; hence the state is entitled to prohibit its use in the public interest. It is certainly clear that the very existence of government entails individual restraints. Whether or not individual freedoms should be curbed with respect to drug use depends on the extent of the threat to society and whether or not the sanctions against it are effective.

. . . One of the most neglected questions in evaluating drug effects concerns the individual benefits which motivate the user. Drug use in many instances may well be an attempt to alleviate symptoms of psychiatric illness through self-medication. In some cases, marihuana use might postpone or prevent more serious manifestations of an illness. Especially for recreational drugs, such as alcohol and marihuana, an objective assessment of user motivation should consider: effectiveness in pro-

ducing pleasure, relaxation, and aesthetic appreciation; enhancement of appetite and other senses; enhancement of interpersonal rapport, warmth, and emotionality; utility of variety or newness of perception and thinking; and enhancement of enjoyment of vacations, weekends, or other periods devoted to recreation, rest, and pleasure.

Other effects of nonmedical drug use may have more far-reaching ramifications for society in general. Does the drug use provide an emotional escape-valve similar to institutionalized festivities employed by other cultures? What is its effect on personality, life style, aggressiveness, competitiveness, etc.? Does it affect military effectiveness through increased passivity? Would its adoption by large numbers affect the direction of society? For example, the use of peyote changed the direction of the American Indian culture by creating a pan-Indian movement—the hippies would advocate a similar cure for the ills of the present society.

In considering the effectiveness of legal sanctions against the use of a drug, three related questions must be considered at the outset: (1) How many persons would abuse the drug if legal controls were removed or not adopted? (2) Do the laws deter use, or perhaps encourage it, as has been suggested with relation to rebellious youth? (3) Is the drug abuser a sick person who, if one drug is prohibited, will find another drug or some equally destructive behavior as a substitute? More specifically, each of these questions must be examined in the context of criminal sanctions against both the user and the distributor as opposed to sanctions against sale only.

Clearly, if the law protects against a non-existing harm, society is better off without the law. The recent elimination of all laws pertaining to written pornography in Denmark, for example, apparently resulted in no ill effects. The incidence of marihuana use as opposed to LSD use supports the position that legal penalties are by no means the overriding determiner of drug usage. The number of persons who have used marihuana is several times that for LSD and is increasing in spite of severe penalties. LSD usage is apparently declining because of concern over the hazards rather than because of any deterrent effect of the relatively moderate laws.

The argument that the drug abuser would simply find another means of escape or self-destructive behavior if the drug were not available is probably only partially

correct. It is clear that persons are more vulnerable to the abuse of drugs at certain times in their lives, such as during adolescence or other highly stressful periods. If a potential drug-of-abuse is unavailable at these times, an undesirable chain of events may well be avoided. Also, it is known that alcoholism results from sociogenic as well as psychogenic causes, and marihuana abuse can undoubtedly follow a similar pattern.

Concerning the kind of drug-control laws which should be enacted and enforced, there is general agreement that the government has not only the right but also the obligation to enforce certain practices with regard to the distribution of drugs. Disagreement exists as to the point at which the advantages of restricting availability are outweighed by the harm resulting from the illicit supplying of the demand for the drug, such as occurred during the prohibition of alcohol.

Regulation, as opposed to prohibition, permits the orderly control of potency and the conditions of sale, such as age of purchaser, hours of sale, and licensing. It also permits taxation and eliminates the support of organized crime as well as the criminogenic aspects of forcing the user to deal with illegal sources. On the other hand, prohibition of sale clearly indicates social disapproval, whereas open sale does not.

Arguments for criminal sanctions against the drug user primarily stress: (1) their deterrent effect and (2) the aid such laws give to enforcement agencies in apprehending sources of supply. Major arguments against such laws stress that enforcement inevitably encourages the violation of constitutional guarantees of privacy, as well as various other practices, such as informers posing as students, hippies, or other potential drug users, which are ethically questionable though technically legal.

The social control of drug use is most difficult to handle via legal means when the drug in question permits both use and abuse; e.g., alcohol and marihuana. The problem of penalizing the majority because of the abuse by the minority was specifically dealt with by the Supreme Court at the time of the Volstead Act. The Court ruled that the state had the right to deny access to alcohol to those who would not abuse it in order to remove the temptation from those who would abuse it.

On a few occasions, exceptions have actually been carved out of the law to permit use of a drug otherwise prohibited; e.g., sacramental use of wine and religious use of peyote by the Indians. More frequently,

society has informally disregarded the enforcement of the law for various groups, conditions, or in certain districts of the city. For example, during the '40s, police frequently overlooked the use of marihuana by jazz musicians because they were otherwise productive and did not cause trouble. Another means of allowing use but controlling abuse is through compulsory treatment.

What is especially needed is a concerted effort to produce congruence among the various drug policies and laws. What we have at present is an assortment of approaches which are not only lacking in consistency but often operate in clearly opposite directions. Much of the incongruity is based on unrecognized attitudes and fears which must be made conscious and explicit before a congruent policy can emerge. One means of forcing some of the most glaring inconsistencies into perspective is to treat alcohol abuse and drug abuse as a single problem, an approach suggested by the World Health Organization.

A rational approach to reducing the harm caused to society by excessive drug use must include examination of the contributions of the massive advertising programs for alcohol and tobacco and weigh this against the economic and other costs of intervening in our free enterprise system. If public drunkenness is the manifestation of an illness to be treated rather than punished, is dependency on other drugs not also an illness?

We should critically examine the legal reasoning which concludes that being an addict is not a crime, but possessing the substance necessary to be an addict is a felony deserving a five- or ten-year sentence. The methods of controlling narcotics supply should be weighed against the expense to the victims burglarized, the increased number of prostitutes, and the large profits to organized crime, all of which accompany illegal drug traffic. The deterring effect of the current marihuana laws should be evaluated against the resulting alienation, disrespect for the law, and secondary deviance involving a sizeable portion of an entire generation.

Finally, in a somewhat speculative vein, part of the lack of congruence among drug policies in this country may be due to the fact that economic and technological factors are changing at a faster rate than are cultural attitudes and values. The drug laws in the country have always been an attempt to legislate morality, although they have been justified in terms of preventing antisocial acts. These laws and attitudes evolved

at a time when the Protestant ethic and the competitive, achievement-oriented value system were very much in dominance. The freely chosen, passive withdrawal to a life of drug-induced fantasy was an extremely threatening concept.

Now we are told we are verging on an economy of abundance rather than scarcity; an age of automation will eliminate half or more of the labor force necessary for the production of goods. The concept of work will have to be redefined to include non-productive pursuits which are now considered hobbies; a guaranteed annual income program will likely be in effect within five or ten years. The children of today's middle class have never experienced a depression or any appreciable difficulty in satisfying their material needs. They do not share the materialistic value system to the same extent as their parents because they have little fear of material deprivation.

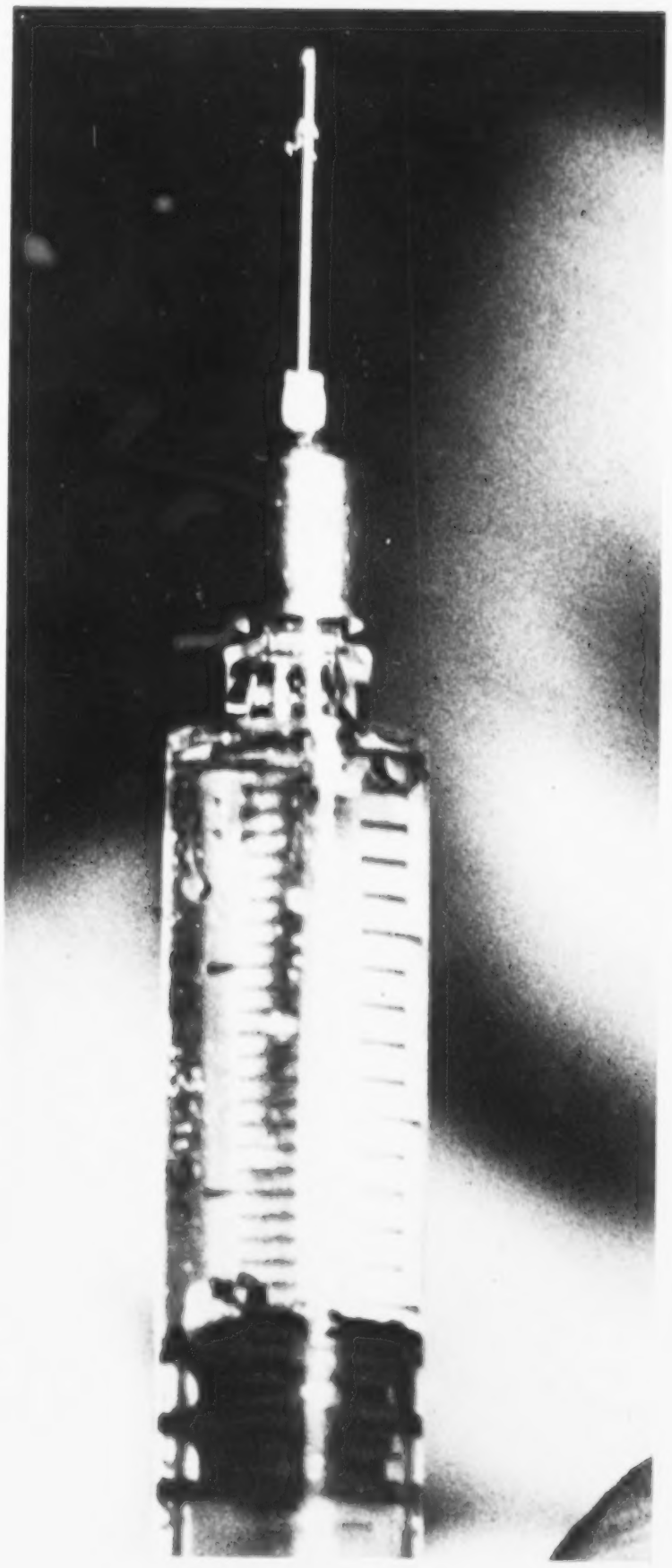
There also appears to be an increasing acceptance of pleasure in its own right rather than as something that needs to be earned as a reward for hard work. The traditional American attitude toward pleasure was quite evident in the opinion recently given by Judge Tauro in upholding the constitutionality of the Massachusetts marihuana laws. In denying that the fundamental right to the pursuit of happiness is violated by the marihuana laws, he argues that such rights must be "essential" to continued liberty and are particularly those "closely related to some commonly acknowledged moral or legal duty and not merely to a hedonistic seeking of pleasure." In affirming that the state was justified in permitting alcohol and prohibiting marihuana, Judge Tauro argued that alcohol was used most frequently as a relaxant and "as an incident of other social activities," whereas marihuana was "used solely as a means of intoxication," i.e., pleasure.

If the age of economic abundance, automation, and greatly increased leisure time become a reality, it is doubtful that these viewpoints toward pleasure (hedonistic and otherwise) can survive. Excessive drug use would be seen as a threat to the individual—not as "a threat to the very moral fabric of society." The overall welfare of society would be much less dependent on the productivity of the individual, and a value system which demands that pleasure be earned through work would be obsolete.

In conclusion, whether or not the age of abundance arrives, social policy, with some minor reversals, will

probably move in the direction of permitting greater individual freedom with respect to drug use. Society will promote the concept of allowing adults the privilege of informed decision. The crucial problem which will remain is that of protecting those who are too young to make an informed decision.

71



7

DRUG EDUCATION IN GRADES TEN, ELEVEN, AND TWELVE*

SANDRA K. FLORSTEDT

Editorial Note

The primary objective of a drug education program is to help youth develop a framework of knowledge and values enabling them to make sound, responsible decisions in all areas of living.

Other major *objectives of drug education are to help students:*

(1) make intelligent decisions regarding the use of drugs.

(2) identify and explore social, physical, and psychological reasons for using drugs.

(3) develop an awareness and understanding of societal and familial pressures which may lead a person to drug abuse.

(4) become aware of the pressures that peer groups exert in the use of drugs.

(5) become aware of one's motivations, feelings, and fears which might lead to drug use.

(6) explore ways in which the individual can deal with problems and tensions without resorting to excessive drug use.

(7) become knowledgeable of laws (state and federal) relating to drugs and drug abuse.

(8) become aware of community resources available for problems of drug abuse and emotional disturbance.

*"Drug Education in Grades Ten, Eleven, and Twelve," written by Sandra K. Florstedt, under the auspices of the Connecticut Department of Mental Health, April, 1969, pp. 2-12. Reproduced with permission of the Connecticut Department of Mental Health.

(9) *develop increased self-awareness and sensitivity to the feelings and communications of others.*

(10) *achieve greater facility in relating to other people.*

In view of the above objectives, the following outline for a drug education program in grades ten through twelve is reproduced.

D.J.W.

Maximum student participation follows the axiom that *doing* is still the most effective learning activity known—a bit more taxing on the teacher, but definitely an experience for the student. The idea is to prepare the student for a productive adulthood through supervised experiences simulating those he will be encountering. Course materials will consist predominantly of the types of materials a person comes across routinely: newspapers, television, music, art forms, movies, radio, popular books. The teacher should also require that use be made of local libraries, professional organizations, and town, state, and federal agencies until he is satisfied that the student *knows how to find any information he desires.*

In some cases the teacher will introduce materials for discussion or assign readings for individual evaluation. All members of the class should be alert for items of interest to the others. ... It is strongly recommended that most classroom materials be of a current nature or that they be student-gathered items and information.

If this is to be a unit geared to the relationship of the student to the community, some arrangement should be made to bring the student to the problem, i.e., research outside the classroom. "Actually exploring a local community's organization, problems, and attitudes makes this unit a meaningful one."*

An activity should be considered which students can follow-up with *action* directed toward a stated desirable change. The students should be able to see for themselves that they have effected some change, even a minute one. A situation in which the students feel involved and responsible (the closer to home the better) would be ideal. The group should therefore be guided into choosing a small-scale project which they are capable of grasping, analyzing, and taking constructive action. For example, a study of health education in a

*Unless otherwise specified, all quotations in this chapter are from the *State of Washington Health Education Guide to Better Health*, prepared under the supervision of the State Office of Public Instruction, Olympia, Washington, 1966.

local elementary school would be more productive than tackling health education in the United States.

If individual school circumstances make working away from the premises impossible, a project concerning a school health problem could work well. The student is interested, involved, and usually willing to make a personal commitment to positively influencing a school health problem.

In addition to the activity project, a *survey* or research study of a larger national or international health problem could be undertaken if time allows. The objective behind such a study would be an understanding of the problem. Direct action or intervention will not be a principal goal. The class should, however, discuss seriously any ideas for improving the situation. Requiring that they be written-up will force students to clarify their thinking.

A copy of their recommendations with a brief description of the class study should be submitted to the school principal and, most important, to the head of the agency handling the problem. Through his reply, however brief, the students will sense that they have established contact with a specific person at the administrative level. For this reason also, the teacher should be alert for situations in which letters to Congressmen or other policy-makers would be appropriate.

Suggested Concepts and Activities

The following [material] has been compiled to be read with a selective eye. The topics are intended to span three grades—ten, eleven, and twelve. Those a particular teacher chooses to present will depend upon his students and his own teaching preferences. The ultimate decision of which to use with a given class rests entirely with the teacher.

In general, the order follows that of three stages of normal development. The areas of concentration in a high school course of drug education will be (1) Relationship of Individual to Society, (2) Student's Projection of Himself as an Adult, and (3) Community Health and Social Welfare.

Most of these topics are not intended to be presented formally for discussion as the topic of the day. Ideally, they should be related to material used in class or introduced at the appropriate time into a student discussion. This is especially true of those topics which are so general in nature that they apply to an infinite number of situations beyond those involving drug use.

I. *Motives, Alternatives, and Subsequent Decision-Making:*

A. Students should examine the forces which influence their behavior. These forces are complex and create perplexing alternatives regarding health practices. (By this age students should realize that deliberate and informed decisions affect the level of well-being.) It is important for them to *acknowledge the variety and influence of motivations* before proceeding to the *evaluation of alternatives* and finally to *decision-making.*

1. Discuss the concept that factors which influence a person to use drugs may be physical, mental, and social. The student should be encouraged to consider how each of these possibilities might apply to him. Students will come up with others which should be added to the teacher's notes.

   PHYSICAL: status of health, fatigue, pleasure, boredom, craving, pain.

   MENTAL: desire for relaxation, loss of inhibitions, or general change of mood based on his *expectations* of what the drug will do for him.

   SOCIAL: customs, social patterns ("pill society," social use of alcohol), desire to elicit group acceptance and approval.

   In the same way list those which might cause a person to *not* use drugs.

B. There are a number of ways in which a person can respond to any given situation. Examine the conflicts these alternatives create, the possible decisions, and the outcomes of each. How does one decide? What happens if no conscious decision is made (and carried out)? Point out that conscious and deliberate decision-making is based on *knowledge:*

   OF HIMSELF: values, personal goals, attitudes, status of health, personal limitations and strengths, his previous experiences.

   OF OTHERS (SPECIFIC INDIVIDUALS): his relationships with them, their influence on the characteristics listed under "himself," his responsibility to them, their expectations of him.

   OF HIS PHYSICAL ENVIRONMENT: laws of science (e.g., effect of a drug), the physical setting in which he moves.

C. The student should be encouraged to examine his own value system i.e., those goals which he considers to be important and desirable in life. He should devote thought to projecting how present behavior patterns will affect future goals, mental health, and physical health.

D. The habitual use of drugs is related to psychological and social drives. Habituation to tobacco, alcohol, and over-the-counter-drugs should be included in the discussion.

E. Illustrate the "easy out" of defense mechanisms in situations which make us uncomfortable. A psychology textbook will provide definitions and examples.

F. An emotionally mature person does not attempt to escape reality by the excessive use of drugs/alcohol.

1. Note the characteristics of an emotionally mature vs. an emotionally immature individual. This is not an easy issue in which to draw definite lines. What seems emotionally mature to one student might seem objectionable to another. In general the teacher can help by pointing out that mature individuals face day-to-day problems realistically, recognize strengths and weaknesses, and basically like and accept themselves and others.
2. Discuss: Why do some people drink when they know they are becoming dependent upon alcohol? List ways of reducing tension without the use of alcohol. (Teacher and students must understand already that alcohol is a *depressant* and thus reduces tension.)

II. *Responsibility for the Mental and Physical Health of Others:*

A. A person's responsibility for others is based upon his age and sex.

Examine the responsibilities of:

Parent for child
Child for parent
Husband for wife
Wife for husband
Sibling for sibling
Community for community
Citizen for community

Examine the responsibilites of:

Citizen of one country for citizen of another ("Brotherhood of man" concept).

B. "The emotional climate of home, school, community, and world influences the mental health of individuals."

1. "Itemize the basic needs of children. Give specific examples of ways parents might meet the needs of children.
2. Discuss the situation of "going off to war" as motivation for participating in premarital sexual experience with a loved one.
3. Discuss the pros and cons of mothers working."
4. Investigate the effect of cultural deprivation on individuals.
5. Discuss the pressure the draft exerts on young men of high school age and up.
6. Investigate the pressures of poor people. Does this correlate with a higher incidence of known mental illness? Drug addiction? Alcoholism?

C. You can affect other people's mental and physical health.

Examples:

MENTAL—giving criticism, being a friend. Discuss the concept of inflicting mental pain.

PHYSICAL—giving a friend a pill "which helps me so it will help you." Mother's responsibility for feeding family. Involving another person in an accident.

1. Discuss: How can we contribute positively to the well-being of someone who is not an acquaintance? Let our money work through an established agency. Work to prevent auto accidents. Be a concerned driver yourself.
2. Discuss: How can we contribute positively to the mental health of a parent, sibling, girl or boy friend, casual contacts (e.g., saleslady), even teacher! (Note: *Understanding* and *accepting* is positive.)
3. Discuss: The issue of getting involved in street crimes where a person's health is being threatened.

III. *Relationship of Individual to Society:*

A. The need to belong is a powerful force.

1. "What happens when there is a conflict between what you want to do and what the group wants to do?"
2. "Dramatize how it may feel to be different from others in terms of race, nationality, beliefs, customs."

B. Hippie society is based on the adolescent's general need for a group structure, group

values, the emphasis on sharing, and the common distrust of the adult world. Use the filmstrip and teacher's guide to "The Alienated Generation." (Guidance Associates)

C. The drug subculture influences even those who are not members of this group.

Show the effect the drug subculture has on those who do not actually belong:

(a) language
(b) dress
(c) art forms
(d) group behavior (Do you also use these mannerisms when alone?)
(e) values

D. "I'm not hurting anybody but myself"; or "What I do with my body is my own business."

1. When does the right to differ infringe on the rights of others?
2. Direct a pair of students to analyze each of the following areas of social consequences of excessive drug or alcohol use (some also apply to the excessive use of tobacco):

   Family relationships
   Group relationships
   Dropout potential
   Financial demands
   Delinquency and crime

3. Invite a former addict or alcoholic to describe how his experience affected his family relationships, career, and peer relationships. (The teacher should use extreme care in securing this person. It should be arranged through someone he knows to be reliable.)

E. A changing society necessitates adjustments.

1. "Discuss the effect of automation, depersonalization, and isolation on one's concept of usefulness.
2. . . . possible effect on self of going away to school, [looking for a new job], going into the service, etc."

F. To what degree can society be changed? Analyze the potential of one person vs that of a group vs that of the majority of the population.

1. A study of state and federal laws involving narcotic drugs and alcohol is recommended. Several students might arrange to interview an attorney to clarify questions uncovered during their research.
2. Ask a social studies teacher or local legislator to review the legislative process.

3. If the legislature is in session, follow a bill of concern to the class from its conception to its implementation.

IV. *Student's Projection of Himself as an Adult:*

An adolescent's interpretation of the adult world is based on what he observes adults (parents especially) say and do, impressions gained from mass media (How valid are these?), his own experiences with adults, projected extensions of present peer relationships, peer attitudes.

1. Discuss: The satisfactions of adulthood. Ask students to get their parents' viewpoints and report back. (This could give those who need it a good *reason* to have a personal conversation with their parents.)
2. Using a projection into the future ten years from now, have students discuss:
   (a) Their "present" occupational, financial, and marital status.
   (b) Their accomplishments in life.
   (c) Their analysis of their attitudes toward themselves at age eighteen. (Make sure their attitude toward drug abuse and alcohol is included.)
   (d) Their feelings about the use of drugs, alcohol, and tobacco by their own children.

V. *Community Health and Social Welfare:*

This section is a vital one to the development of good citizenship. It is rich with potential student activity and personal involvement experiences. For this reason, among others, it is a good place to begin the course, especially if time is limited. Concepts of great personal concern to the student will usually fall into place during discussions. A number of excellent teaching suggestions related to this topic are given in the states of Washington and New York health education guides. Several are included in this outline.

Student objectives of this section can be identified as basically three:

"To acknowledge that as part of a community he can positively or negatively affect health conditions.

To realize, furthermore, that he can effect change in these conditions if change is necessary and desirable."

To become acquainted with the government agencies, community, and professional organizations that concern themselves with health and social welfare.

A. The abuse of drugs creates health and social problems of major proportions in our time. These problems become the responsibility and concern of all citizens.
   Form buzz groups to discuss questions of particular interest to the class in connection with drug abuse. Questions may be formulated by the class in open discussion; they may be controversial queries collected in the question box; or they may consist of items such as the following assigned by the teacher:
   1. When a person uses drugs illegally, is it his own business or is it the concern of all of us?
   2. What is my responsibility if I suspect that a friend of mine is engaging in some form of drug abuse?
   3. Should I refrain from using a drug merely because it is illegal, or should I base my judgment on my own opinion and my own set of values? (In other words, should I obey laws because they are laws, or should I select those laws which I wish to obey and those I wish to disobey?)
   4. "Does a man have the right to glorify inner experience and become disinterested in the world of other men?"[1]

B. The manufacture and distribution of drugs is strictly supervised by the federal government:
   1. Determine the testing procedure used by the FDA.
   2. Write to the home office of a large drug company requesting a lecture by their local representative on the development, manufacture, and distribution of drugs.
   3. What regulations must manufacturers of cigarettes, cosmetics, and alcoholic beverages observe in the preparations of their products?
   4. Review the thalidomide problem of 1962. How did the drug get into the hands of persons in the U.S.? Was it approved by the FDA? How were the side effects traced to this drug? Has the drug been taken off the market in the U.S. and Europe? What improvements have been made to prevent this type of situation?
   5. Request the class to choose a small committee to interview a pharmacist regarding the operation of legal controls that govern the use of prescription drugs. If more than one class is planning this activity, arrange

to have only one committee represent all the classes. The information that is obtained from the interview should be saved for future use in other classes receiving this instruction. An alternative to the interview would be to invite the pharmacist to speak to the class about these matters. Should the latter choice be made, encourage the students to raise questions for which they want answers or to identify any points that need clarification.

6. Direct one or two volunteers to consult law enforcement officials concerning the extent to which controlled drugs are used illegally in the community and to identify some of the problems these officials encounter in their effort to stop such practices.

C. Project in Community Health:

1. Study local health and welfare problems. The town Health Officer or local police or a town welfare worker will be able to help identify problem areas.

2. Select one aspect of a local problem connected with drugs for a class or group project. Students should plan and carry out a survey of the problem, then work to change it.

3. Suggestions for health activities within the school itself:
   (a) Determine alcohol or drug use of students.
   (b) Study the availability of help in school for personal problems: Discuss how an individual may recognize that he needs help. Invite a school counselor to discuss help available from the guidance department. Sample students to find out whether they use the guidance department and if not, why not.

4. Tackle research on a wider-scale health problem. If at all possible, a small group should visit treatment facilities, health and welfare agencies, or arrange interviews with specific professionals in the field.

FOOTNOTE

[1]Helen H. Nowlis, *Drugs on the College Campus*, Garden City, New York: Doubleday and Company, Anchor Books, 1968, p. 50.

8

FOUR RULES FOR TEACHING ABOUT DRUGS

DONALD J. WOLK

The topic of drug usage often causes teachers (and parents) to feel uncomfortable and defensive. Contradictory theories, inconclusive research findings, and uncertain "facts" are plentiful. Moreover the teacher is weighted down with the task of telling students to stay away from drugs—not to educate them about the effects of drugs (good and bad) on individual and society. He is placed in a straightjacket of administrative and parental pressures, a difficult position if one is to educate in an unbiased manner. All too often, onesided scare tactics are ineffective, especially for those youngsters who have already used drugs, and for those who are still walking the fence.

Students "are confronted with a mass of claims and counterclaims [regarding marijuana]: the 'scare' rhetoric by those who would advocate more repressive actions is matched by the counter-arguments of those advocating more permissive policies, who deny a cause for alarm and, in many instances, claim a potential for enjoyful and mind-expanding experience. For those without immediate reference to experience—either their own or that of close peers—this debate can only increase a sense of distrust, if not cynicism. For those with experience for reference, the arguments of the permissives—even if they promise more than marijuana can

deliver—turn out to be confirmed more often not."[1] Moreover, "exaggerated and disprovable claims for the effects of marijuana may . . . encourage experimentation with more immediately dangerous drugs by discrediting all warnings."[2]

The teacher cannot afford to become a preacher—not in this day and age. Today, information about drugs, politics, sex, social class, racial inequities, and international affairs is disseminated by a variety of media—only one of these being the classroom teacher.

It is well to consider that a major influence on an individual's use of drugs is the peer group. The prestige of key figures, and the power of group approval, identification, and belongingness are tremendous motivating factors.

The teacher is no longer the indisputable authority. To delude himself with the belief that his word will be heeded or to indulge in self-pity and frustration if his teachings are ignored can be fatal to communication. He must be prepared to take a flexible approach, maintaining, at the very least, an open mind to the range of student feelings and attitudes. If he accepts or condemns too quickly, without knowledge or feeling, he only perpetuates the anxiety, the resentment, and the defensiveness of the younger generation. When discussing the topic of drugs the teacher must be a student in his own class; he must become a participant-observer, a guide or a facilitator—but not "The Teacher"!

Following are four basic rules that can serve as a guide to thinking through the problem of teaching about drug use:

(1) Although the topic is drug use, drugs, *per se*, are not always of prime concern. Major areas for discussion are: (a) The personal meaning in taking drugs, (b) implications for one's life style, (c) one's interpersonal relationships, and (d) future goals.

(2) Know the facts, fantasies, and uncertainties about drugs and drug use. A thorough knowledge of chemical and physical effects is not as necessary as a concerned awareness of the psychological and sociological effects and reasons for use.

(3) Present an objective view of drug use and abuse. Do not limit discussion to the dangers or negative side and avoid anything remotely positive; present as fair a picture as possible. Avoid moralizing and making quick judgments (positive or negative).

However, do not inhibit the expression of your own opinions and values. Carefully think through and then

express and discuss the rationale for your way of thinking; offer this as simply another point of view.

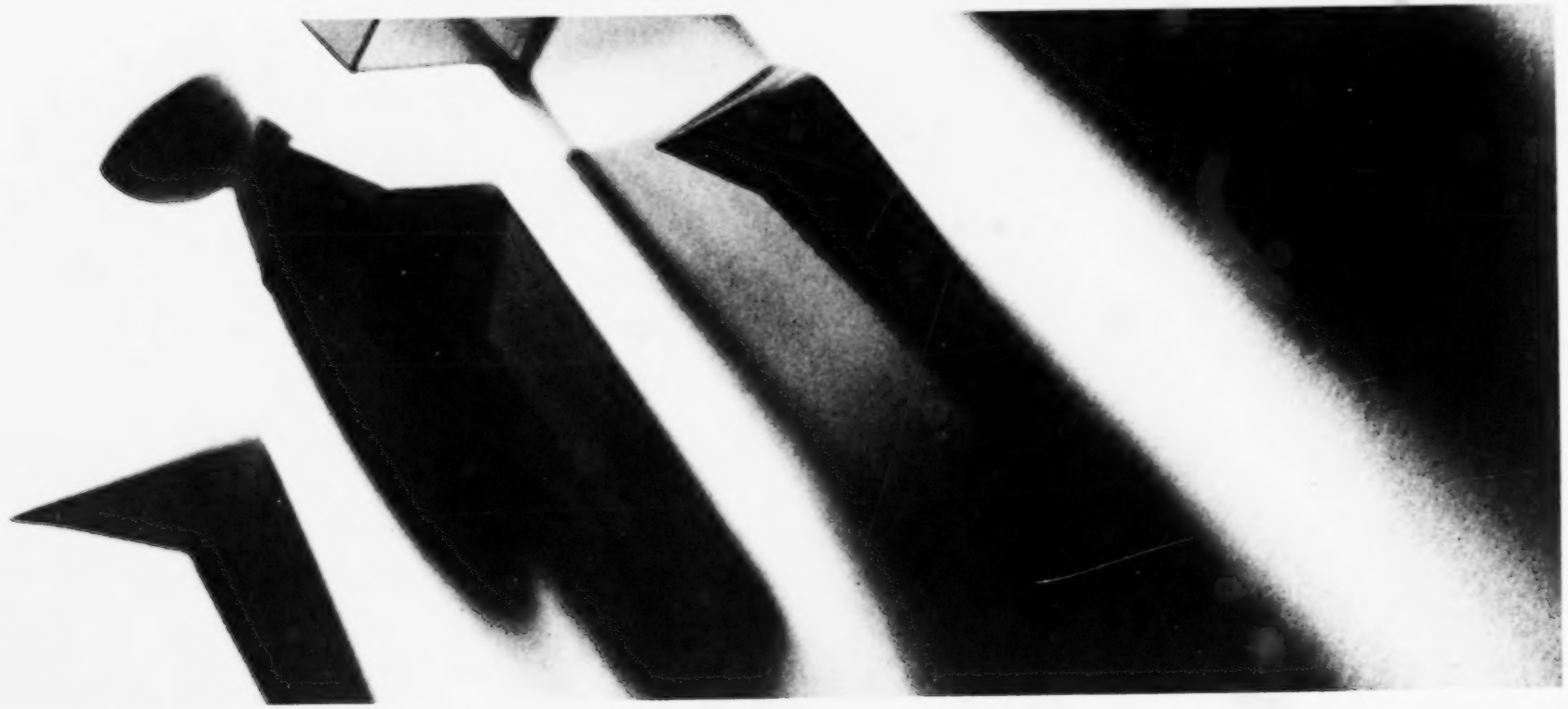
Allow discussion from all sides, requesting questions and comments, both written and oral. If an attempt is made to "brainwash," you will lose those students you most want to reach, and who probably want to be reached.

(4) Finally, learn from your students. Do not regard yourself as the authority or as the only teacher in the room. In an atmosphere of openness and inquiry, you are apt to learn more about drug use and student feelings and attitudes than you may believe possible.

FOOTNOTES

[1]W. Simon and J. H. Gagnon, "Children of The Drug Age," *Saturday Review*, September 21, 1968, p. 63.

[2]*Ibid.*



APPENDIX:

PRACTICAL DRUG INFORMATION FOR TEACHERS

80 Chart Listing Drugs, Medical Uses, Symptoms Produced and Their Dependence Potentials

82 Drug Glossary

85 Selected Annotated Bibliography

88 Drug Films

93 Examples of Drug Education Curricula

Drug Chart *

Chart Listing Drugs, Medical Uses, Symptoms

(Question marks indicate

Name	Slang name	Chemical or trade name	Source	Classification	Medical use	How taken
Heroin	H., Horse, Scat, Junk, Smack, Scag, Stuff, Harry	Diacetyl-morphine	Semi-Synthetic (from Morphine)	Narcotic	Pain relief	Injected or Sniffed
Morphine	White stuff, M.	Morphine sulphate	Natural (from Opium)	Narcotic	Pain relief	Swallowed or Injected
Codeine	Schoolboy	Methylmorphine	Natural (from Opium), Semi-Synthetic (from Morphine)	Narcotic	Ease Pain and coughing	Swallowed
Methadone	Dolly	Dolophine Amidone	Synthetic	Narcotic	Pain relief	Swallowed or Injected
Cocaine	Corrine, Gold Dust, Coke, Bernice, Flake, Star Dust, Snow	Methylester of benzoylecgonine	Natural (from coca, NOT cacao)	Stimulant, Local Anesthesia	Local Anesthesia	Sniffed, Injected or Swallowed
Marijuana	Pot, Grass, Hashish, Tea, Gage, Reefers	Cannabis sativa	Natural	Relaxant, Euphoriant, In high doses Hallucinogen	None in U.S.	Smoked, Swallowed, or Sniffed
Barbiturates	Barbs, Blue Devils, Candy, Yellow Jackets, Phennies, Peanuts, Blue Heavens	Phenobarbital Nembutal, Seconal, Amytal	Synthetic	Sedative-hypnotic	Sedation, Relieve high blood preasure, epilepsy, hyper-thyroidism	Swallowed or Injected
Amphetamines	Bennies, Dexies, Speed, Wake-Ups, Lid Prop-pers, Hearts, Pep Pills	Benzedrine, Dexedrine, Desoxyn, Meth-amphetamine, Methedrine	Synthetic	Sympatho-mimetic	Relieve mild depression, con-trol appetite and narcolepsy	Swallowed or Injected
LSD	Acid, Sugar, Big D, Cubes, Trips	d-lysergic acid diethylamide	Semi-Synthetic (from ergot alkaloids	Hallucinogen	Experimental study of mental function, alcoholism	Swallowed
DMT	AMT, Businessman's High	Dimethyl-triptamine	Synthetic	Hallucinogen	None	Injected
Mescaline	Mesc.	3,4,5-trimeth-oxyphenethyl-amine	Natural (from Peyote)	Hallucinogen	None	Swallowed
Psilocybin		3 (2-dimethyl-amino) ethylin-dol-4-oldihydro-gen phosphate	Natural (from Psilocybe)	Hallucinogen	None	Swallowed
Alcohol	Booze, Juice, etc.	Ethanol ethyl alcohol	Natural (from grapes, grains, etc. via fermentation)	Sedative hypnotic	Solvent, Antiseptic	Swallowed
Tobacco	Fag, Coffin nail, etc.	Nicotinia tabacum	Natural	Stimulant-sedative	Sedative, Emetic (nicotine)	Smoked, Sniffed, Chewed

*Source: National Clearinghouse for Mental Health Information, *Resource Book for Drug Abuse Education*. Chevy Chase, Maryland: National Institute of Mental Health, 1969.

Produced and their Dependence Potentials

conflict of opinion)

Usual Dose	Duration of effect	Effects sought	Long-term symptoms	Physical dependence potential	Mental dependence potential	Organic damage potential
Varies	4 hrs.	Euphoria, Prevent withdrawal discomfort	Addiction Constipation Loss of Appetite	Yes	Yes	No
15 Milligrams	6 hrs.	Euphoria, Prevent withdrawal discomfort	Addiction Constipation Loss of Appetite	Yes	Yes	No
30 Milligrams	4 hrs.	Euphoria, Prevent withdrawal discomfort	Addiction Constipation Loss of Appetite	Yes	Yes	No
10 Milligrams	4–6 hrs.	Prevent withdrawal discomfort	Addiction Constipation Loss of Appetite	Yes	Yes	No
Varies	Varies, Short	Excitation Talkativeness	Depression Convulsions	No	Yes	Yes?
1–2 Cigarettes	4 hrs.	Relaxation, increased euphoria, Perceptions, Sociability	Usually None	No	Yes?	No
50–100 Milligrams	4 hrs.	Anxiety reduction, Euphoria	Addiction w/ severe withdrawal symptoms, Possible convulsions, toxic psychosis	Yes	Yes	Yes
2.5–5 Milligrams	4 hrs.	Alertness Activeness	Loss of Appetite Delusions Hallucinations Toxic psychosis	No?	Yes	Yes?
100–500 Micrograms	10 hrs.	Insightful experiences, exhilaration, Distortion of senses	May intensify existing psychosis, panic reactions	No	No?	No?
1–3 Milligram	Less than 1 hr.	Insightful experiences, exhilaration, Distortion of senses	?	No	No?	No?
350 Micrograms	12 hrs.	Insightful experiences, exhilaration, Distortion of senses	?	No	No?	No?
25 Milligrams	6–8 hrs.	Insightful experiences, exhilaration, Distortion of senses	?	No	No?	No?
Varies	1–4 hrs.	Sense alteration Anxiety reduction, Sociability	Cirrhosis Toxic psychosis Neurologic damage, Addiction	Yes	Yes	Yes
Varies	Varies	Calmness Sociability	Emphysema, Lung cancer, mouth & throat cancer, cardiovascular damage, loss of appetite	Yes?	Yes	Yes

Drug Glossary*

Acid	LSD, LSD-25 (lysergic acid diethylamide)
Acidhead	Frequent user of LSD
Bag	Packet of drugs
Ball	Absorption of stimulants and cocaine via genitalia
Bang	Injection of drugs
Barbs	Barbiturates
Bennies	Benzedrine, an amphetamine
Bindle	Packet of narcotics
Blank	Extremely low-grade narcotics
Blast	Strong effect from a drug
Blue angels	Amytal, a barbiturate
Blue velvet	Paregoric (camphorated tincture of opium) and Pyribenzamine (an antihistamine) mixed and injected
Bombita	Amphetamine injection, sometimes taken with heroin
Bread	Money
Bum trip	Bad experience with psychedelics
Bummer	Bad experience with psychedelics
Busted	Arrested
Buttons	The sections of the peyote cactus
Cap	Capsule
Chipping	Taking narcotics occasionally
Coasting	Under the influence of drugs
Cokie	Cocaine addict
Cold turkey	Sudden withdrawal of narcotics (from the gooseflesh, which resembles the skin of a cold plucked turkey)
Coming down	Recovering from a trip
Connection	Drug supplier
Cop	To obtain heroin
Cop out	Quit, take off, confess, defect, inform
Crash	The effects of stopping the use of amphetamines
Crash pad	Place where the user withdraws from amphetamines
Crystal	Methedrine, an amphetamine
Cubehead	Frequent user of LSD
Cut	Dilute drugs by adding milk, sugar, or another inert substance
Dealer	Drug supplier
Deck	Packet of narcotics
Dexies	Dexedrine, an amphetamine
Dime bag	$10 package of narcotics
Dirty	Possessing drugs, liable to arrest if searched
Dollies	Dolophine (also known as methadone), a synthetic narcotic

*Source: *A Federal Source Book: Answers to the Most Frequently Asked Questions about Drug Abuse*, 1970. Distributed by the National Clearing House for Drug Abuse Information, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

Doper	Person who uses drugs regularly
Downers	Sedatives, alcohol, tranquilizers, and narcotics
Drop	Swallow a drug
Dummy	Purchase which did not contain narcotics
Dynamite	High-grade heroin
Fix	Injection of narcotics
Flash	The initial feeling after injecting
Flip	Become psychotic
Floating	Under the influence of drugs
Freakout	Bad experience with psychedelics; also a chemical high
Fuzz	The police
Gage	Marihuana
Good trip	Happy experience with psychedelics
Goofballs	Sleeping pills
Grass	Marihuana
H	Heroin
Hard narcotics	Opiates, such as heroin and morphine
Hard stuff	Heroin
Hash	Hashish, the resin of Cannabis
Hay	Marihuana
Head	Person dependent on drugs
Hearts	Dexedrine tablets (from the shape)
Heat	The police
High	Under the influence of drugs
Holding	Having drugs in one's possession
Hooked	Addicted
Hophead	Narcotics addict
Horse	Heroin
Hustle	Activities involved in obtaining money to buy heroin
Hustler	Prostitute
Hype	Narcotics addict
Joint	Marihuana cigarette
Jolly beans	Pep pills
Joy-pop	Inject narcotics irregularly
Junkie	Narcotics addict
Kick the habit	Stop using narcotics (from the withdrawal leg muscle twitches)
Layout	Equipment for injecting drug
Lemonade	Poor heroin
M	Morphine
Mainline	Inject drugs into a vein
Maintaining	Keeping at a certain level of drug effect
(The) Man	The police
Manicure	Remove the dirt, seeds, and stems from marihuana
Mesc	Mescaline, the alkaloid in peyote
Meth	Methamphetamine (also known as Methedrine, Desoxyn)
Methhead	Habitual user of methamphetamine
Mikes	Micrograms (millionths of a gram)

Narco	Narcotics detective
Nickle bag	$5 packet of drugs
O. D.	Overdose of narcotics
On the nod	Sleepy from narcotics
Panic	Shortage of narcotics on the market
Pillhead	Heavy user of pills, barbiturates or amphetamines or both
Pop	Inject drugs
Pot	Marihuana
Pothead	Heavy marihuana user
Purple hearts	Hexamyl, a combination of Dexedrine and Amytal (from the shape and color)
Pusher	Drug peddler
Quill	A matchbook cover for sniffing Methedrine, cocaine, or heroin
Rainbows	Tuinal (Amytal and Seconal), a barbiturate combination in a blue and red capsule
Red devils	Seconal, a barbiturate
Reefer	Marihuana cigarette
Reentry	Return from a trip
Roach	Marihuana butt
Roach holder	Device for holding the butt of a marihuana cigarette
Run	An amphetamine binge
Satch cotton	Cotton used to strain drugs before injection; may be used again if supplies are gone
Scag	Heroin
Score	Make a purchase of drugs
Shooting gallery	Place where addicts inject
Skin popping	Injecting drugs under the skin
Smack	Heroin
Smoke	Wood alcohol
Snorting	Inhaling drugs
Snow	Cocaine
Speed	Methedrine, an amphetamine
Speedball	An injection of a stimulant and a depressant, originally heroin and cocaine
Speedfreak	Habitual user of speed
Stash	Supply of drugs in a secure place
Stick	Marihuana cigarette
Stoolie	Informer
Strung out	Addicted
Tracks	Scars along veins after many injections
Tripping out	High on psychedelics
Turned on	Under the influence of drugs
Turps	Elixir of Terpin Hydrate with Codeine, a cough syrup
25	LSD (from its original designation, LSD-25)
Uppers	Stimulants, cocaine, and psychedelics
Weed	Marihuana
Works	Equipment for injecting drugs
Yellow jacket	Nembutal, a barbiturate

Selected Annotated Bibliography

Abramson, H. S. (editor), **The Use of LSD in Psychotherapy and Alcoholism.** New York: Bobbs-Merrill Company, 1967.

LSD use is examined in reference to psychotherapy, alcoholism, probation case work, and childhood schizophrenia. Case studies from therapy used in conjunction with LSD are especially interesting; theoretical explanations for the effect and results of this experience are reported. This book is highly recommended for those who wish to understand the beneficial aspects of LSD.

Ausubel, D. P., **Drug Addiction: Physiological, Psychological and Sociological Aspects.** New York: Random House, 1958.

Although some attention is given to marijuana and barbiturates, the primary focus is opiate addiction. Well-written sections on heroin offer readers a practical and theoretical understanding of addiction. Physiological, psychological, and sociological causes and results of heroin use are explored. Contents also include a brief history of opiates, and treatment methods and programs for heroin addicts.

Blum, Richard and Associates, **Society and Drugs,** Vol. 1 (Social and Cultural Observations); **Students and Drugs,** Vol. 2 (College and High School Observations). San Francisco: Jossey-Bass, 1969.

Volume 1 includes brief histories of marijuana, alcohol, stimulants, hallucinogens, tobacco, and cocaine. Normal drug use and drugs and crime are also discussed. Volume 2 is of major interest and usefulness. The authors report their research findings among college and high school students, including student characteristics and motivation regarding drug use; life styles of drug users; psychiatric problems related to the use of drugs; and student attitudes and views toward drugs and drug education.

Carey, J. T. and J. Mandel, "A San Francisco Bay Area 'Speed' Scene," ***Journal of Health and Social Behavior,*** (2):164–174, June, 1968.

An examination of the social, psychological, and physical effects of amphetamines upon heavy users, based on interviews and observations. The use of Methedrine is discussed with objectivity, but written in an absorbing, colorful manner.

Chein, I., Gerard, D. L., Lee, R. S., and Rosenfeld, E., **The Road to H.** New York: Basic Books, 1964.

A book entirely devoted to the use of heroin, with detailed psychological and sociological analyses of male and female addicts. Economic, cultural, and family factors are examined analytically and statistically. Based on research conducted in New York City, this book is a readable, significant work on heroin addiction.

Cohen, S., **The Beyond Within: The LSD Story.** New York: Atheneum, 1964.

Data from patient reports and from research studies are the basis of this book. Positive and negative effects of the LSD experience are objectively reported. One of the chapters could be a subtitle: "Model Psychosis or Instant Zen?". An intriguing, thought-provoking book.

De Ropp, R. S., **Drugs and the Mind.** New York: Grove Press, Inc., 1957.

Mescaline, marijuana, heroin, barbiturates, and alcohol are the primary drugs presented, with historical data, research, case reports, and self-observation. A fascinating and informative book.

Fort, J., M.D., "Pot: A Rational Approach," ***Playboy***, October, 1969.

A well-written, documented article advocating liberalization of present drug laws, especially those pertaining to marijuana.

Gunther, M., "Will the U.S. Ever Legalize Pot?", ***True*** (magazine) July, 1969.

Based on a survey of students, police, and congressmen. A "must" for those who wish further information on the pros-and-cons of legalizing marijuana.

Jacobson, C. B. and Magyar, V. L., "Genetic Evaluation of LSD," **Clinical Proceedings** (of the Children's Hospital of the District of Columbia), 24 (5), May, 1968, pp. 153-161.

An objective assessment of the possible dangers of LSD on chromosomes, and the risk of genetic damage to future generations. Concise and informative.

Louria, D. B., **The Drug Scene.** New York: McGraw-Hill Book Company, 1968.

With the focus on youth, this book offers various aspects of drug use and abuse, psychological and sociological causes, effects and consequences, and drug use in the United States and in European countries. Contains good chapters on marijuana, and methods of opiate treatment. Book could be better organized, but a strong and colorful writing style contribute to make it worthwhile reading.

McGlothlin, William H., "Social and Para-Medical Aspects of Hallucinogenic Drugs," in **The Use of LSD in Psychotherapy and Alcoholism,** edited by H. A. Abramson. Indianapolis: The Bobbs-Merrill Co., Inc., 1967.

Peyote (from which mescaline is derived) and marijuana are the focus of this brief article. Terse summaries of the history, effects, and motivation for each drug are presented. Cultural variations are explored in an effective manner.

Simon, W. and Gagnon, J. H., "Children of the Drug Age," ***Saturday Review,*** September 21, 1968.

A penetrating article about marijuana use by youngsters. Sociological and psychological reasons for the proliferation of this drug are examined. The authors' presentation is emotionally and intellectually stimulating.

Simons, J. L., and Winogard, B., **It's Happening.** Santa Barbara: More/Laird Press, 1966.

A provocative account of the youth scene—drugs, sex, social and personal attitudes and responsibility, the deterioration of the Protestant Ethic, today's hedonistic society. Book will generate insight, empathy, anger, fascination.

Solomon, D. (editor), **The Marihuana Papers.** Indianapolis: Bobbs-Merrill Co., Inc., 1966.

A collection of papers ranging from a detailed history of marijuana to literary accounts and scientific reports of the effects and consequences of marijuana use. Although the book describes both positive and negative aspects of the drug, it is primarily pro-marijuana. Included in the volume is the now-famous New York City or LaGuardia research report on marijuana use in the 1930's.

Unger, S. M., "Mescaline, LSD, Psilocybin, and Personality Change: A Review," ***Psychiatry,*** 26, 1963, pp. 111–125.

Stressing LSD, the focus of inquiry is "extra-drug factors," i.e., effect and influence of the setting, mood and motivation of the subject, and the person administering the drug. Personality change is briefly explored.

Zinberg, N. E. and Weil, A. T., "A Scientific Report—The Effects of Marijuana on Human Beings," ***The New York Times Magazine,*** May 11, 1969, p. 28; (also in **Science,** December, 1968).

An objective study of the physical and psychological effects of marijuana. Findings based on laboratory research overturn some myths regarding marijuana.

D.J.W.

Drug Films*

Suggestions on the Use of Films in Drug Abuse Education

by David O. Weber
Film Consultant
California Department of Public Health
and Joseph Fiorelli
Audiovisual Specialist

Users of LSD say that the quality of a trip depends on several factors. One is the grade of acid taken. Another is dosage—a fledgling will almost certainly fly on 250 micrograms while the same amount may barely get a hardened tripster off the ground. Two other essential factors are the "set" and the "setting."

Set means the ideas, the mood, the rationales a user carries with him into the experience. If he is fearful, antagonistic before he begins his trip, he is likely to have a bummer.

Or, if the setting is wrong—unpleasant physical surroundings, bad vibrations from those around him, distracting noises or lights or music—even a positive set can be negated.

The use of drug films to educate young people about dangers of drugs can be compared with the use of LSD.

First, the quality of films, as of drugs, varies widely. Many films still in circulation have lost their potency through age. Hats, hems, automobiles, outmoded slang, may distract from and vitiate the message, no matter how timeless. Or, a film which is up-to-date visually may be hopelessly marred by jingoistic phrases and atavistic attitudes. "Know your dealer," they say in the streets. Applied to films, this translates to know something about the producers of films whose use is contemplated and, if at all possible, sample the dose in advance by previewing them before an audience that will not be harmed if the film is bad.

In addition to quality, drug abuse films vary in type. Some take the sociological approach, warning against the loss of income, status, dignity, even freedom (if jailed) attendant upon addiction. Some are purely descriptive of drugs and their effects. Some show in great detail the ways drugs can be abused. Some maintain a studiously determined distance. Some are dramatizations, some documentaries, some lectures, some cinematic essays. Most are a combination.

Some project a tone of moral outrage, others a tone of cool scientific detachment. Some attempt to deal with a broad spectrum of drugs—these are fewest in number and probably the most needed—others treat only one drug or one class of drugs. Needless to say, none of these films will give audiences identical trips.

It might be worthwhile to ponder in advance what functions a film should perform:

For example, is one purpose of a drug film to show teenagers

*Source: National Clearinghouse for Mental Health Information, *Resource Book for Drug Abuse Education*. Chevy Chase, Maryland: National Institute of Mental Health, 1969.

how heroin is prepared and injected, how marihuana is smoked, how glue is inhaled—so that they can recognize and avoid these situations when encountered? Should a film be propaganda, supplying the moral element to the classroom's dispassionate discussions?

Should a film, because it lists a lot of doctors as consultants, be considered unimpeachable authority? Or should it be questioned, and if necessary demolished, in the presence of its audience? As set down, of course, these are loaded questions. Unfortunately, most drug films are similarly loaded.

The next consideration in selecting a drug abuse film, to continue our LSD metaphor, should be the set. What's the mood and character of the audience? Obviously, rural junior high school students will find little to identify with in a film about big-city junkies. Nor will ghetto blacks do much but cackle at the cinematic drug despair of an affluent, blond, sports-car-driving Kampus-King protagonist. Only through careful assessment of the set of an audience can a film user hope to turn it on meaningfully.

Finally, the setting must be such that the trip will be good, not bad. Most drug film audiences are captive. They can't question the film about obscure points, they can't argue with it (though they can catcall and mutter). If their boredom threshold is breached, they nod off.

Guides to the use of films are difficult to set forth because each teacher and teaching situation is different. However, there are some basic rules that if followed improve chances of success.

A good rule to start with is to be as wary of films as of drugs. Some precautions to be kept in mind are: Don't trust a film to be good just because someone says it is; no one film is good for every situation . . . Don't trust even a good film to contain only accurate information . . . Don't trust one expert; consult several.

If possible, preview a film before ordering it. That failing, request delivery several days in advance of the scheduled showing in order to view it, preferably with a few teachers or students whose opinions and reactions will be helpful.

Do not hesitate to use only portions instead of complete films, filmstrips, or tapes. Imaginative teachers have put together excellent shows by combining parts of several films.

Before a showing, check equipment to be sure it is mechanically and optically satisfactory. Ideally, back-up projectors and sound equipment should be on hand in case of an equipment breakdown. If there is a breakdown and no back-up, it is usually better to postpone the presentation entirely than to interrupt it for a lengthy repair job.

Room arrangements should be checked to assure sufficient darkness and satisfactory viewing from all seats. Materials should be racked and ready so that the film showing can start immediately after the introduction. If something intervenes between the introduction and the showing, the meeting should be brought back into the proper setting by a reintroduction.

Generally, no film should be used for educational purposes without oral introduction or explanation. The introducer can tell the purpose of the film showing, reasons for selecting

the film, what to look for in it, what questions or reactions will be discussed after the showing.

Ample discussion time should be scheduled to follow film showings. The discussion period may contribute more to the desired objectives than the film showing.

Nothing should be permitted to interrupt a film showing. Unless latercomers can enter without distracting the audience, the entrance door should be barred.

Where practical, audiences should be kept small. A large group can be separated into sub-groups if necessary. In intimate groups, comments and criticisms come more freely, and there is opportunity to correct errors, misunderstandings, and inaccurate inferences.

Some think that, for teaching purposes, all films should be shown twice, with a discussion period in the middle and perhaps another one following. It is a possibility to be considered.

Listing of Drug Abuse Films

Caution: No film gives all the answers, and some bring more problems than solutions. Preview any film before showing it, match the film to the audience, remembering that no film is suitable for every audience. Encourage viewers to discuss it pro and con afterwards.

Purchase and rental prices are given where possible.

Prints may often be borrowed from State or local health departments, film libraries, boards of education, and from regional offices of the Bureau of Narcotics and Dangerous Drugs.

Free loan prints of many of these films may be obtained from the National Institute of Mental Health Drug Abuse Film Collection, National Audiovisual Center, General Services Admin., Washington, D.C. 20409.

Title	Length B&W or color	Coverage	Target Audience	Producer or Distributor	Purchase or Rental
DRUG ABUSE: THE CHEMICAL BOMB 1969	19 min. color	Barbiturate pills, methedrine, glue & deliriants, marihuana	Jr & Sr. High School, suburban	Film Distributors International, 2223 S. Olive St., Los Angeles 90007	Purchase $225 Rental Information on request
CBS REPORTS: MARIHUANA 1968	52 min. B&W	Marihuana	Sr. High School, Adult, General	Carousel Films, Inc. 1501 Broadway, New York 10036	Purchase $275 Rental $20
LSD: THE TRIP TO WHERE 1968	28 min. color	LSD	Sr. High School, Adult	McGraw Hill Films, Hightstown, New Jersey 08520	Purchase $325 Rental $16 daily
WORLD OF THE WEED 1968	21 min. B&W	Marihuana	Sr. High School, College, Adult	NET Film Service, Indiana University Audio-visual Center, Bloomington, Indiana 47401	Purchase $125 Rental $4.65
THE LAW: HOW EFFECTIVE IS IT? 1968	36 min. B&W	Marihuana	Sr. High School, Adult, General	NET Film Service, Indiana University Audio-visual Center, Bloomington, Indiana 47401	Purchase $180 Rental $7.40

Title	Length B&W or color	Coverage	Target Audience	Producer or Distributor	Purchase or Rental
RESEARCH REPORT: THC—THE CHEMISTRY OF MARIHUANA 1968	36 min. B&W	Marihuana (THC)	Adult	NET Film Service, Indiana University Audio-visual Center, Bloomington, Indiana 47401	Purchase $180 Rental $7.40
LSD, TRIP—OR TRAP 1968	20 min. color	LSD	Jr. & Sr. High School, College	Sid Davis Productions, 2429 Ocean Park Blvd. Santa Monica, Calif. 90405	Purchase $240–color $120–B&W No rental
ESCAPE TO NOWHERE 1968	25 min. color	LSD, marihuana Hashish Heroin Methamphetamine	Suburban Sr. High School, Students, suburban adults	Professional Arts, Inc., P.O. Box 8484, Universal City, California 91608	Purchase $275 Rental $27.50, 3 days
THE DISTANT DRUMMER 1968	three 22-min. films Color	LSD Methedrine Marihuana Heroin	Adults	National Institute of Mental Health Drug Abuse Film Collection	Free loan
MARIHUANA 1968	34 min. color	Marihuana	Jr., Sr. H.S., College, Adults	Bailey-Film Associates, 11559 Santa Monica Blvd. Los Angeles 90025	Purchase $350 Rental $25, 3 days
THE MIND BENDERS—LSD & THE HALLUCINOGENS 1968	26 min. color	LSD Psilocybin Mescaline DMT	Sr. High School College	National Medical Audiovisual Center Chamblee, Ga. 30005	
BEYOND LSD 1968	25 min. color	"Drug-taking" in general	Middle Class suburban adults	Film Associates of Calif., 11559 Santa Monica Blvd., Los Angeles, Calif. 90025	Purchase $300
LSD: INSIGHT OR INSANITY? 1968	28 min. color	LSD	Jr., Sr. H.S. Adults	Bailey-Film Associates, 11559 Santa Monica Blvd. Los Angeles 90025	Purchase $300 Rental $25, 3 days
DRUGS & THE NERVOUS SYSTEM 1967	18 min. color	Aspirin, glue Amphetamines Barbiturates Opiates, LSD Marihuana	Jr., Sr. H.S. Adults	Churchill Films 662 N. Robertson Blvd., Los Angeles, Calif. 90069	Purchase $170 color
NARCOTICS: THE INSIDE STORY 1967	12 min. color	Narcotics LSD Marihuana Tranquilizers Sedatives	Jr., Sr. High School	Charles Cahill & Assoc., Inc. P.O. Box 3220 Hollywood, Calif. 90028	Purchase $145 No rental
THE HIPPIE TEMPTATION 1967	51 min. (Pt. I, 31 min., Pt. II, 20) color	LSD	General Sr. High School Adults	McGraw-Hill Films Hightstown, New Jersey 08520	Purchase $600 ($300 ea. part)
THE CIRCLE 1967	57 min. B&W	Heroin	Adult, General	McGraw-Hill Films, Hightstown, New Jersey 08520	Purchase $340 Rental $15 daily
THE SEEKERS 1967	10 min. color	Heroin Marihuana LSD	Sr. High School	State of New York Drug Addiction Control Commission Albany, N.Y. 12203	
HOOKED 1967	20 min. B&W	Heroin	Jr., Sr. High School	Churchill Films, Inc., 662 N. Robertson Blvd. L.A., Calif. 90027	Purchase $125

Title	Length B&W or color	Coverage	Target Audience	Producer or Distributor	Purchase or Rental
LSD: LETTVIN VS. LEARY 1967	54 min. B&W	LSD, Marihuana	Adult, general	NET Film Service Indiana University Audiovisual Center Bloomington, Ind. 47401	Purchase $210 Rental $8.90
LSD 25 1967	27 min. color	LSD	Sr. High School, College, Adults, General	Professional Arts, Inc., P.O. Box 8484 Universal City, Calif. 91608	Purchase $275 Color
LSD 1967	28 min. color	LSD	U.S. Navy personnel	Audiovisual Branch U.S. Navy, Pentagon, Washington, D.C. 20301	Purchase $114.39
FIGHT OR FLIGHT 1967	16 min. color	Heroin, LSD Marihuana "Pills" alcohol cough med.	Jr., Sr. High School	J & F Productions, Inc., Suite 700 1401 Walnut Street Phila., Pa. 19102	Purchase $150 No Rental
FDA SPECIAL REPORT: DRUG ABUSE—BENNIES & GOOFBALLS	20 min. B&W	Amphetamines Barbiturates	Sr. High School Adults	Precision Film Labs., 21 W. 46th St., New York, N.Y. 10036	Purchase $30.79
LSD: THE SPRING GROVE EXPERIMENT 1966	54 min. B&W	LSD	Sr. High School, College, Adults, Professional	McGraw-Hill Films, Hightstown, New Jersey 08520	Purchase $275 Rental $25
HIDE AND SEEK 1966	14 min. color	Heroin Marihuana	Suburban College, Jr., Sr. High School	Center for Mass Communication of Columbia Univ. Press, 440 110th St., New York City 10025	Purchase $150 Rental $11
NARCOTICS: WHY NOT 1966	15 min. color	Heroin Marihuana "Pills" Glue	Jr., Sr. High School, Adults	Charles Cahill & Assoc., Inc., P.O. Box 3220 Hollywood, Calif. 90028	Purchase $175 col. $90 B&W No rental
NARCOTICS: PIT OF DESPAIR 1965	28 min. color	Heroin Marihuana "Pills", Beer Cigarettes	Sr. High School	Film Distributors, International, 2223 S. Olive St., Los Angeles, Calif. 90007	Purchase $275
NARCOTICS: THE DECISION 1961	30 min. color	Heroin Marihuana "Pills" Alcohol	Sr. High School	Film Distributors, International, 2223 S. Olive St., L.A., Calif. 90007	Purchase $275 Rental $17.50
TOMORROW MAY BE DYING 1960	23 min. B&W	Heroin "Pills" Alcohol Aspirin	Sr. High School College	Cinema Dept., Graduate Workshop, Univ. of Southern Calif., Univ. Park, L.A., Calif. 90007	Purchase $138 Rental $6.50
THE LOSERS 1960	31 min. B&W	Heroin Glue "Pills" Marihuana	Adults High School General	Carousel Films, Inc. c/o Association Films, 600 Grand Ave., Ridgefield, N.J. 07657	Purchase $145 Rental $10, Postage
SEDUCTION OF THE INNOCENT 1960	10 min. color	Heroin Marihuana "Pills"	Jr., Sr. High School	Sid Davis Productions, 2429 Ocean Park Blvd., Santa Monica, Cal. 90405	Purchase $120 col. $60 B&W No rental
THE ADDICTED (PART II, CRIMINAL OR PATIENT?) 1958	28 min. B&W	Heroin	Adult General	Association Films, Inc., 600 Grand Ave. Ridgefield, N.J. 07657	Purchase $150 Rental $8.50, Postage

Examples of Drug Education Curricula*

Background

An Interagency Federal Committee was convened in the winter of 1969 under the auspices of the White House to make available to the Nation's schools a variety of state and local curricula for drug education and the prevention of drug abuse. Participating in the Committee chaired by the Office of Education, DHEW, were the Bureau of Narcotics and Dangerous Drugs, Department of Justice; the National Institute of Mental Health, DHEW; and the Office of Economic Opportunity.

As an initial step, the Committee established an Interdisciplinary Panel of non-government professionals to review some of the drug abuse curricula developed by state and local school systems. Time did not permit a review of all curricula in use throughout the country.

The curricula selected are not recommended for adoption, but are distributed only as resources to assist schools in initiating or improving programs. All schools are encouraged to submit curricula and materials to the National Clearinghouse for Drug Abuse Information. These will be reviewed by the Panel and those selected will be made available to other school systems upon request.

Selected curricula have been reprinted with the permission of the originating school systems. Single courtesy copies are available from the National Clearinghouse for Drug Abuse Information.

Curricula Descriptions

Drug Abuse Education, 1968—Grades 6, 9, 12. Baltimore County Board of Education, Towson, Maryland.

Developed during a summer workshop in 1967 and tested in 15 pilot schools, this guide was revised in 1968 and implemented in all 6th, 9th, and 12th grades in the county. The material was designed to be incorporated in 6th grade science, 9th grade science and social studies, and 12th grade social studies classes. Resource kits, which are not reprinted, were developed to accompany this guide.

This guide is organized for each grade level as follows: I. Introduction; II. History of Drug Use; III. Drugs—A. Basic Terms, B. Kinds of Drugs, C. Substances producing drug-like effects (sniffing); IV. Medical Purposes—A. Physiological Relief, B. Psychotherapy; V. Social Consequences of Drug Misuse, and a Summary.

The lessons are formatted in columns headed: Content, Teaching Suggestions, and References. Included in the guide is a resource section with an attitude and opinion survey, a film guide, suggested experiments, suggested reading list for adults, a listing of free and inexpensive materials, and recommendations for library books for senior high schools.

---

*Source: National Clearinghouse for Drug Abuse Information, *Drug Education Curricula Series*, A Descriptive Brochure. Chevy Chase, Maryland. 1970.

Narcotic and Drug Education—Grades K–12. Flagstaff Public Schools, Flagstaff, Arizona.

This guide was developed by a committee consisting of representatives from agencies in the community working in the area of drug abuse. It encourages a positive approach to drug abuse education with sequentially developed content and flexibility to encourage subject integration. Positive attitude development is stressed and decision-making skills are emphasized.

Grouped by grade levels K–3, 4–6, 7–9, 10–12, each unit lists the desired behavioral objectives of knowledge, attitudes, and behavior. Component ideas are outlined with suggested methodology for achieving these goals.

Included are recommendations for an in-service training program, guidelines for selecting resource persons for drug abuse programs in the public schools, and a bibliography.

Tobacco, Drug, and Alcohol Unit—Grade 6. Great Falls School District No. 1, Great Falls, Montana.

This guide sets forth a general educational objective and then outlines the general and specific drug abuse knowledge to be attained. Following this is a listing of desirable skills and attitudes to be gained, suggestions for motivating activities, and teaching hints for slow and rapid learners.

The lessons are formatted in columns headed: Concepts, Teacher Materials, Student Materials, Audio-Visual, Motivating Questions, and Activities. Following are sections titled: Teacher Information, Glossary, Culminating Activities, Evaluation, Sources of Information, and Bibliography.

The unit is based on the premise that the student who is well informed is more apt to make a decision on the basis of facts and common sense. Preaching or scare techniques are discouraged as futile.

Strand II: Sociological Health Problems—Grades 4, 5, 6. New York State Education Department, Albany, New York.

This curriculum guide was developed as Strand II (alcohol, drugs, and smoking) of a five strand approach to health education that encompasses the concepts, generalizations, understandings, and facts; values and applications; basic skills; and decision-making processes that are the keys to good health.

The section on drugs and narcotics contains an overview and a section on desired outcomes based on: I. Early Man's Use of Drugs, II. Modern Drugs and Their Contributions, and III. The Use and Misuse of Drugs.

The lessons have a four column format—Reference, Major Understandings and Fundamental Concepts, Suggested Teacher Aids and Learning Activities, and Supplementary Information for Teachers. A bibliography is included.

An Educational Program Dealing with Drug Abuse—Grades K–12. Rhode Island Department of Education, Providence, Rhode Island.

This guide was devised by an advisory committee as a "crash program" to provide curriculum and resource materials for the 1969–70 school year. It was designed to be flexible

enough to be incorporated into a health program or to be used in science, social studies, or physical education courses at the secondary level. It is divided by grade level, K-3, 4-6, and 7-12. Its general objective is to provide pupils with the knowledge necessary to make intelligent decisions for their own well-being and that of society in regard to the use of addicting or habituating drugs and other potentially harmful substances. Each part contains concepts and understandings which can be developed by the teacher, some suggested learning experiences for the student, and some instructional resource references to which the teacher may turn.

In addition to the basic resource information, the appendix has position papers by members of the advisory committee with expertise in particular areas, a bibliography, information on the student's point of view, and suggested approaches to a drug abuse program.

Drugs and Hazardous Substances—Grades K-12. San Francisco Unified School District, San Francisco, California.

This sequential instructional guide for grades K through 12 was developed to achieve the following major objectives: to guide students in understanding the value systems and motivations that underlie the use, misuse, and abuse of drugs and hazardous substances; to give students an opportunity to examine a wide range of factual information and expert opinion; and to discourage the experimental and recreational use of drugs.

The guide contains sample lesson plans for each grade including a vocabulary for students; information about alcohol, drug use and misuse, and smoking; Federal and State laws pertaining to narcotic and dangerous drug violations; narcotic penalties for the State of California; and a bibliography for teachers. Suggested techniques for evaluating the lessons are also included.

Drug Abuse Education Unit—Grades K-12. South Bay Union School District, Imperial Beach, California.

This guide stresses, "the how, the why, and with what attitudes" drug abuse education should be presented, in building proper attitudes, teaching decision making, and working toward an appreciation of the human body. The basic facts about drugs that will help reinforce these positive attitudes are also presented. Fear tactics are not employed and hard narcotics are not emphasized.

The overall objectives are listed, and the four sections on volatile chemicals, health and appreciation of the human body, advertising propaganda, and the law follow. The lessons have a three column format: Learnings, Pupil Experiences, and References. In addition, numerous illustrations provide ideas for bulletin boards. A bibliography is included.

Curriculum Guide for Drug Education—Grades 6-12. Tacoma Public Schools, Tacoma, Washington.

This guide presents an overview listing the competencies to be attained, concepts to be learned, sample learning experiences, and resource materials.

Four basic guidelines were used in designing these curriculum guides: 1. That community involvement is necessary

and must come first so that adults recognize the problem and act on it; 2. Crash programs are not effective; drug education should not be presented *by staff* but must be integrated into a comprehensive health education program; 3. That assembly-type gatherings and isolated film showings are likely to be ineffective and dangerous in that they focus attention on drugs without providing the students with decision-making information; 4. Staff preparation is necessary and teachers must be thoroughly trained and deeply involved.

Each unit is designed to be incorporated at the appropriate time and place into the existing health education curriculum. In addition to a bibliography for each guide, the preface presents an outline of how the program was developed by utilization of the community, its resources, in-service workshops, and town meetings.